maryland
health services
cost review commission

Quality Policies Webinar

June 21,2023

Agenda

- Introduction
  - Total Cost of Care (TCOC) Model
  - Overview of Pay-for-Performance Programs
- Rate Year 2025 Approved Program Updates
  - MHAC
  - QBR
  - RRIP/Disparity Gap
  - PAU Savings
  - Maximum Guardrail
- Digital Measures Reporting
- CY 2023 Monitoring Reports
- CRISP Reports to Track Hospital and Statewide Progress
  - Hospital Reports
  - SIHIS Reports
- Resources
- Q&A

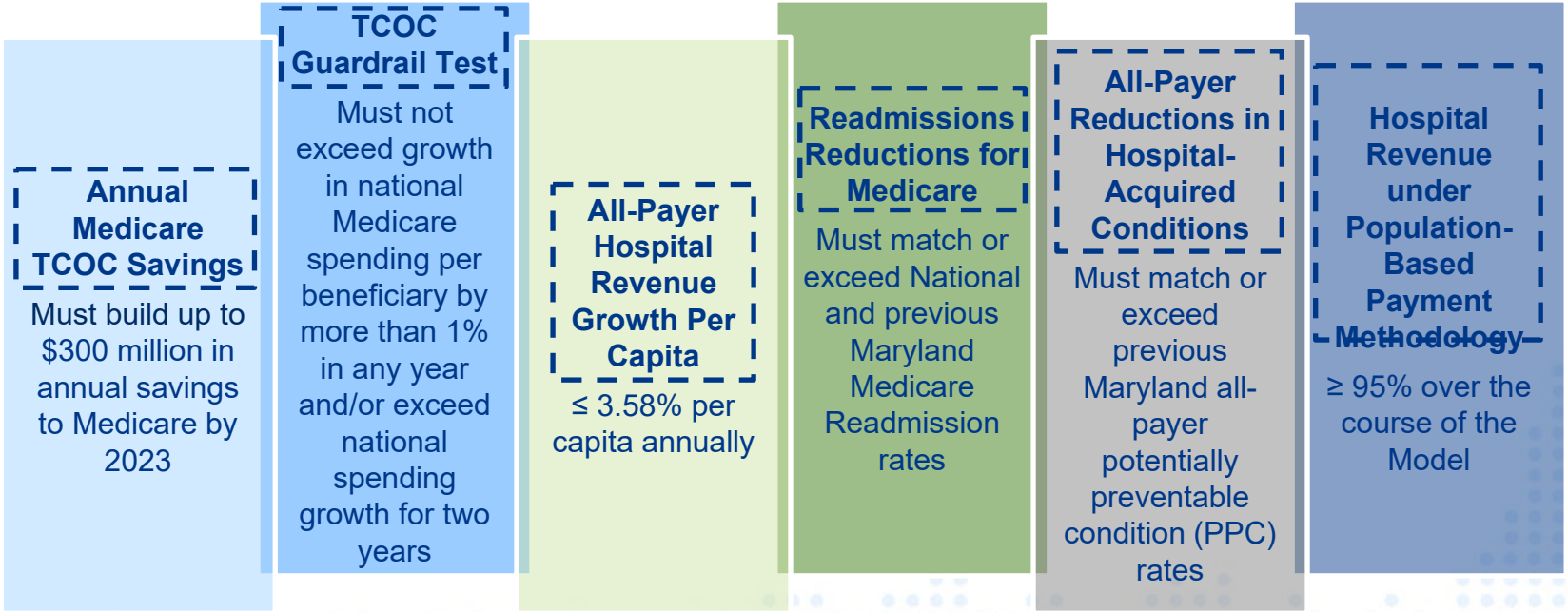
TCOC Model

Transitioning from the All-Payer Model to the Total Cost of Care Model

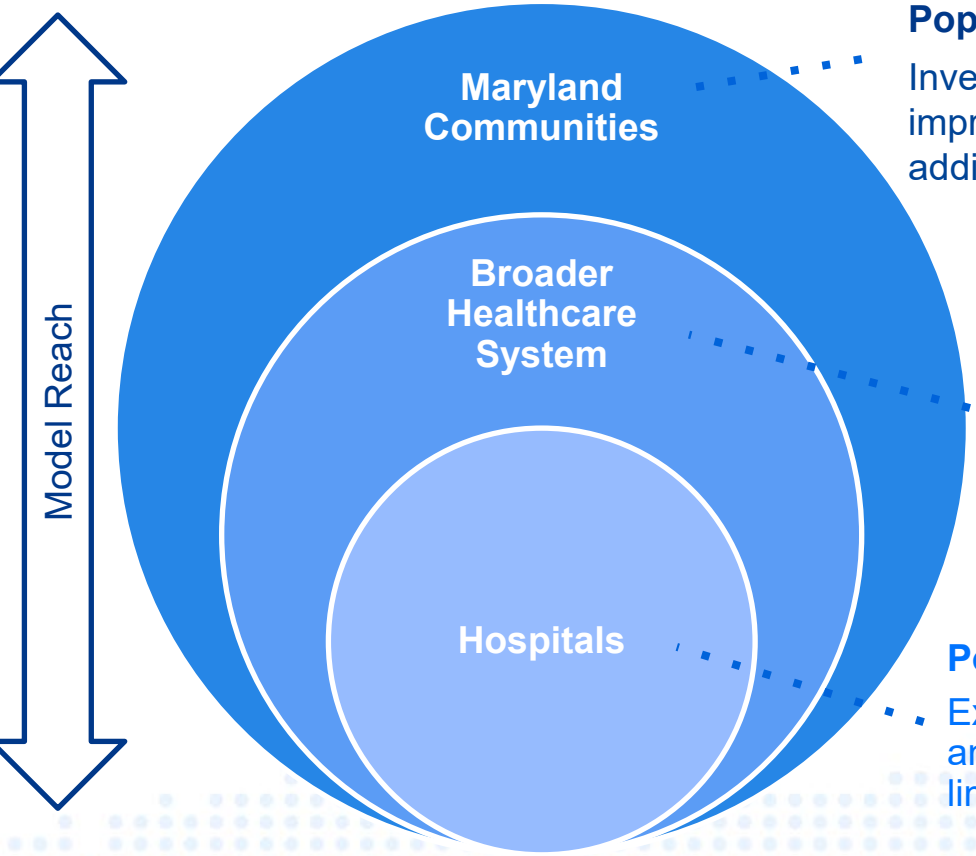
All-Payer Model (2014-2018): **Hospital Focus**	Total Cost of Care Model (2019-2028): **Health System Focus**
Focus on:	Focus on:
Hospital savings	**Total Cost of Care** savings
Hospital quality	Hospital quality and **population health**
Hospital alignment	**System-wide provider** alignment, including opportunities for **primary care** and other **non-hospital providers**

Total Cost of Care (TCOC) Model Targets

The TCOC Model requires the State of Maryland to meet the following targets:



TCOC Model Components



Population Health and Health Equity

Investment in initiatives that aim to make statewide improvements in the areas of diabetes, opioid addiction, and maternal and child health.

Payment and Delivery System Reform

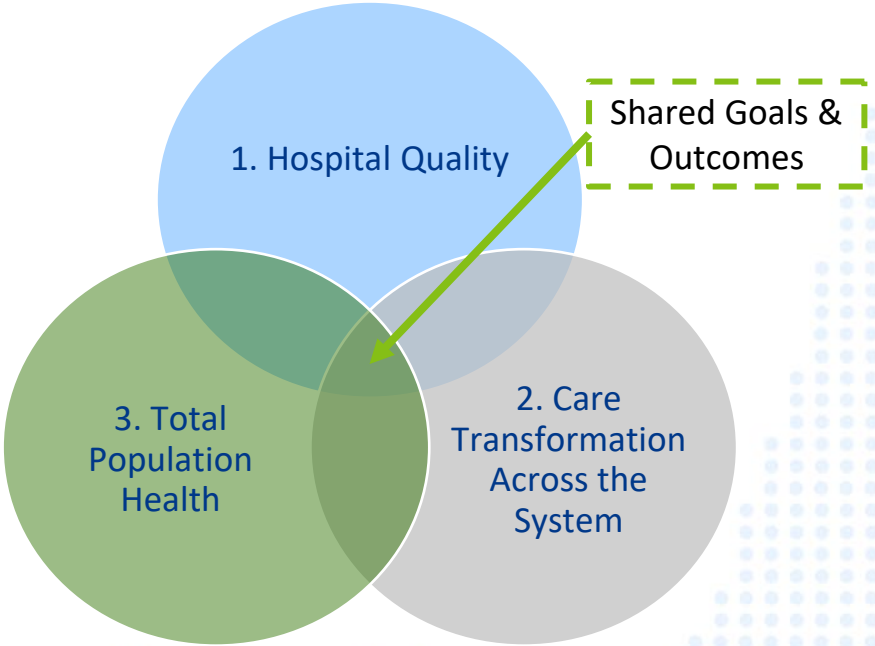
Incentivization of care transformation and partnerships across settings of care by expanding opportunities for non-hospital provider participation in value-based programs

Population-Based Revenue

Expanded hospital quality requirements, incentives, and responsibility to control total costs through limited revenue-at-risk

Statewide Integrated Health Improvement Strategy (SIHIS)

- SIHIS is designed to engage State agencies and private-sector partners to collaborate and invest in improving health, address disparities, and reduce costs for Marylanders.
- CMMI approved the SIHIS goals in March 2021.
- More information on SIHIS can be found on the HSCRC website. https://hscrc.maryland.gov/Pages/Statewide-Integrated-Health-Improvement-Strategy-.aspx



Overview of Pay-for-Performance Programs

HSCRC Performance Measurement Workgroup

- Broad stakeholder group of hospital, payer, quality measurement, academic, consumer, and government agency experts and representatives
- Meets monthly in-person and virtually (3rd Wednesday at 9:30am)
  - Meetings are public, email hscrc.quality@maryland.gov to be added to listserv
- Reviews and recommends annual updates to the performance-based payment programs
- Considers and recommends strategic direction for the overall performance measurement system
  - Align to the extent possible with National measures and strategies
  - Incorporate new measures as available such as emergency department and outpatient measures
  - Broaden focus to patient-centered population health
  - Focus on high-need patients and chronic condition management
  - Build care coordination performance measures

Guiding Principles for HSCRC Performance-Based Payment Programs

- Program must improve care for all patients, regardless of payer
- Program incentives should support achievement of TCOC model targets
- Program should prioritize measures that impact large number of patients, high cost, opportunity for improvement and areas of national focus
- Predetermined performance targets and financial impact
- Hospital ability to track progress
- Reduce disparities and advance health equity
- Encourage cooperation and sharing of best practices
- Consider all settings of care
- Programs should incentivize hospitals to improve the health of communities they serve through primary, secondary and tertiary prevention efforts

Hospital Quality Adjustments

The following are HSCRC's four main quality payment incentive programs:

Maryland Hospital Acquired Conditions (MHAC) Program

Encourages hospitals to reduce infections and complications acquired during a hospital stay

Quality Reimbursement Program (QBR)

Focuses on patient experience, patient safety, and clinical quality outcomes

Readmissions Reduction Incentive Program (RRIP)

Encourages hospitals to reduce readmissions within 30 days of discharge

Potentially Avoidable Utilization (PAU)

Focuses on improving patient care and health through reducing potentially avoidable utilization

HSCRC's quality programs are similar to federal Medicare pay-for-performance programs, but are, wherever possible, All-Payer (instead of Medicare-only) and tailored to address MD's unique quality improvement strategies

RY 2025 Quality Programs

RY 2025 Quality Program Timelines

Rate Year (Maryland Fiscal Year)	Q3-20	Q4-20	Q1-21	Q2-21	Q3-21	Q4-21	Q1-22	Q2-22	Q3-22	Q4-22	Q1-23	Q2-23	Q3-23	Q4-23	Q1-24	Q2-24	Q3-24	Q4-24	Q1-25	Q2-25	Q3-25	Q4-25
Calendar Year	Q1-20	Q2-20	Q3-20	Q4-20	Q1-21	Q2-21	Q3-21	Q4-21	Q1-22	Q2-22	Q3-22	Q4-22	Q1-23	Q2-23	Q3-23	Q4-23	Q1-24	Q2-24	Q3-24	Q4-24	Q1-25	Q2-25
Maryland Hospital Acquired Conditons (MHAC)			MHAC Base Period										MHAC Performance Period*						Rate Year Impacted by MHAC Results			
Quality Based Reimbursement (QBR)												CMS Hospital Compare Performance Period (HCAHPS measures, All NHSN measures)**						Rate Year Impacted by QBR Results			
							Base Period: QBR Maryland Mortality, PSI-90, Follow-up Chronic Conditions															
													Performance Period: QBR Maryland Mortality, PSI-90, Follow-up Chronic Conditions								
		X	Hospital Compare THA/TKA Performance Period***																			
Readmission Reduction Incentives Program (RRIP)			RRIP Base Period#										RRIP Performance Period						Rate Year Impacted by RRIP			
RY 2024 PAU Savings													PAU Savings Performance Period						Rate Year Impacted by PAU Savings			

*Two-year performance period for small hospitals

**CMS Hospital Compare Base Period (HCAHPS measures, All NHSN Measures) CY 2019 Q1-Q4

***Hospital Compare THA /TKA Complications Base Period April 1, 2015-March 31, 2018

X Indicates Data quarters CMS will not use due to COVID PHE

RRIP Base Period for determining attainment standards. RRIP Improvement will be measured from CY 2018

RY 2025 Maryland Hospital Acquired Condition (MHAC) Program

Maryland Hospital Acquired Conditions (MHAC) Program

Purpose

To improve patient care and hospital decision-making by adjusting GBR based on 15 identified potentially preventable complications (PPCs), **complications acquired during a hospital stay** that were not present on admission

- PPCs can lead to **poor patient outcomes, including longer hospital stays, permanent harm**, and **death**, and **increased costs**.
- **Examples of PPCs** include an accidental laceration during a procedure, improper administration of medication, hospital-acquired pneumonia

How it Works: Revenue-at-Risk

The program puts **2 percent** of inpatient hospital revenue at risk (maximum penalty/reward)

Federal Alignment

The MHAC Program is **similar to the federal Medicare HAC Reduction Program (HACRP)** but is all-payer, uses a Maryland-specific list of PPC measures, and does not relatively rank hospitals in assigning financial rewards and penalties.

RY 2025 Data Details

- “Base” Period: July 2020-June 2022
  - Used for calculation of performance standards and normative values for case-mix adjustment
  - Used to determine hospital specific PPC exclusions
  - Used to determine small hospitals
- Performance Period: CY 2023
- 3M APR-DRG and PPC Grouper Version 40

MHAC Methodology

Overview of MHAC Methodology

Potentially Preventable Complication Measures

List of 15 clinically significant PPC included in payment program.

Acute Pulmonary Edema & Respiratory Failure w/o Ventilation	Post-Operative Infection & Deep Wound Disruption Without Procedure	In-Hospital Trauma & Fractures
Acute Pulmonary Edema & Respiratory Failure w/ Ventilation	Post-Operative Hemorrhage & Hematoma w/ Hemorrhage Control Procedure or I&D Proc	Septicemia & Severe Infections
Pulmonary Embolism	Accidental Puncture/Laceration During Invasive Procedure	Pneumonia Combo
Shock	Iatrogenic Pneumothorax	Other Complications of Obstetrical Surgical & Perineal Wounds
Venous Thrombosis	Major Puerperal Infection & Other Major Obstetric Complications	Encephalopathy

Global Exclusions:

- Discharges >6 PPCs
- APR-DRG SOI cells with less than 31 at-risk discharges

Hospital PPC Exclusions:

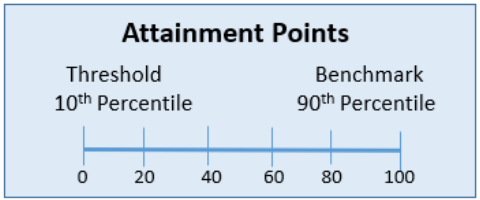
- <20 at-risk discharges
- <2 expected PPCs

Case-Mix Adjustment and Standardized Scores

Performance Measure: CY 2023* Observed to Expected PPC Ratio.

Expected calculated by applying statewide average PPC rates by diagnosis and severity of illness level to hospitals' patient mix (i.e., indirect standardization)

Attainment only score (0-100 points) calculated by comparing hospital performance to a statewide threshold and benchmark.



July 2020-June 2022 used to calculate statewide averages (norms) and thresholds, benchmarks.

*Small hospitals will be assessed on CYs 22 & 23

Hospital MHAC Score & Revenue Adjustments

Hospital MHAC Score is Sum of Earned Points / Possible Points with PPC Cost Weights Applied.

Scores Range from 0-100%
Revenue neutral zone 60-70%

Max Penalty -2% & Reward +2%

MHAC Score	Revenue Adjustment
0%	-2.00%
10%	-1.67%
20%	-1.33%
30%	-1.00%
40%	-0.67%
50%	-0.33%
60% to 70% Hold Harmless	0.00%
80%	0.67%
90%	1.33%
100%	2.00%

Performance Metric

- Hospital performance is measured using the Observed(O) / Expected(E) ratio for each PPC
- Lower number = better performance
- Expected number of PPCs for each hospital are calculated using the base period statewide PPC rates by APR-DRG and severity of illness (SOI)
  - See Appendix of the MHAC Final Recommendation or annual memo for details on how to calculate expected numbers

Normative values for calculating expected numbers are included in the MHAC Summary reports on the CRS portal

Adjustments to PPC Measurement

- Adjustments are made to improve measurement fairness and stability
- For each hospital, discharges will be excluded if:
  - The discharge has > 6 PPCs (i.e., catastrophic cases)
  - The discharge is in an APR-DRG SOI group with less than 31 statewide discharges
- For each hospital, PPCs will be excluded if during the base period:
  - The number of discharges at-risk is less than 20
  - The number of expected cases is less than 2
- Two years of performance data (CY 22 & 23) are used for small hospitals
  (i.e., hospitals with less than 21,500 at-risk discharges and/or 22 expected PPCs across all payment program PPCs)

The list of hospital specific excluded PPCs is included in the MHAC Summary workbook on the CRS portal

RY 2025 Payment PPCs

Data on each payment PPC is included in the MHAC Summary Report on the CRS Portal.

PPC Number	PPC Description
3	Acute Pulmonary Edema and Respiratory Failure without Ventilation
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation
7	Pulmonary Embolism
9	Shock
16	Venous Thrombosis
28	In-Hospital Trauma and Fractures
35	Septicemia & Severe Infections
37	Post-Operative Infection & Deep Wound Disruption without Procedure

PPC Number	PPC Description
41	Post-Operative Hemorrhage & Hematoma w/ Hemorrhage Control Procedure or I&D
42	Accidental Puncture/Laceration During Invasive Procedure
47	Encephalopathy NEW RY2025
49	Iatrogenic Pneumothorax
60	Major Puerperal Infection and Other Major Obstetric Complications
61	Other Complications of Obstetrical Surgical & Perineal Wounds
67	Pneumonia Combo (with and without Aspiration)

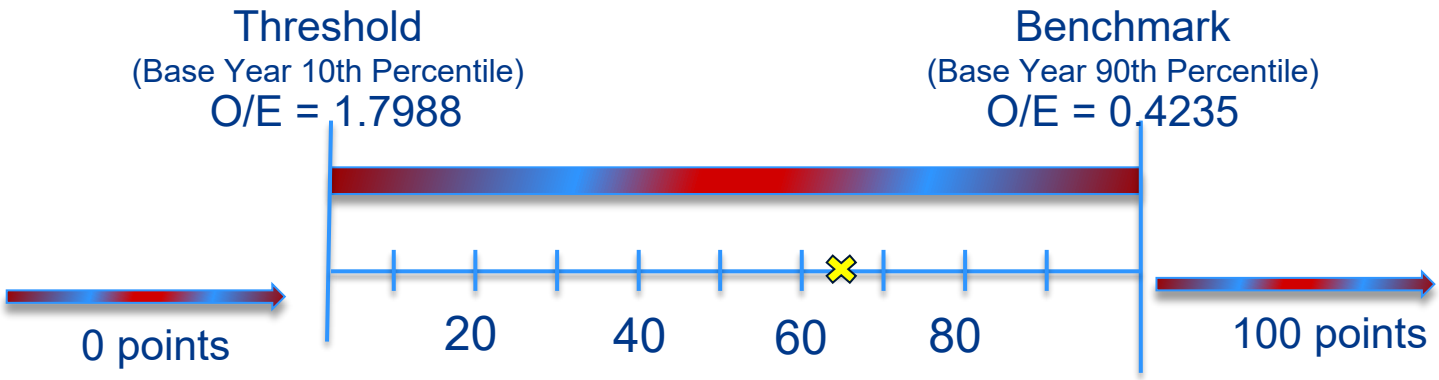
PPC Scoring: Benchmarks and Thresholds

- RY 2025 uses FY2021 and FY2022 (post COVID) to determine performance standards for each PPC
- A threshold and benchmark value for each PPC/PPC combo are calculated based upon the base period data
  - Used to convert O/E ratio for each PPC to points (0-100)
  - Threshold = 10th percentile
  - Benchmark = 90th percentile
- Monitoring reports provide performance results for all PPCs

Thresholds and Benchmarks for each payment PPC are included in the MHAC Summary Report on the CRS Portal.

MHAC Score: Attainment Score

PPC 9 Shock – Attainment Score



Hospital O/E ratio = 0.90

Calculates to an attainment score of 65

3M Cost-Based Weights: Proxy for Harm

The cost estimates are the relative incremental cost increase for each PPC, which can be a proxy for the harm of the PPC within the hospital stay.

Hypothetical Example with Three PPCs: Weights Applied to Scores								
	PPC	Attainment Points	Denominator	Unweighted Score	Weight	Weighted Attainment Points	Weighted Denominator	Weighted Score
Hospital A Worse on Higher Weighted PPCs	PPC X	10	10		0.5	5	5	
	PPC Y	5	10		1	5	10	
	PPC Z	3	10		2	6	20	
		18	30	60%		16	35	46%
Hospital B Worse on Lower Weighted PPCs	PPC X	3	10		0.5	1.5	5	
	PPC Y	5	10		1	5	10	
	PPC Z	10	10		2	20	20	
		18	30	60%		26.5	35	76%

Version 40 PPC Cost Weights are included in the MHAC Summary Report on the CRS Portal.

RY 2025 Payment PPCs Cost Weights

PPC Number	PPC Description	3M v40 PPC Cost Weight
3	Acute Pulmonary Edema and Respiratory Failure without Ventilation	0.5005
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation	1.5519
7	Pulmonary Embolism	1.1248
9	Shock	1.0478
16	Venous Thrombosis	1.5503
28	In-Hospital Trauma and Fractures	0.3379
35	Septicemia & Severe Infections	1.4394
37	Post-Operative Infection & Deep Wound Disruption without Procedure	1.5936

PPC Number	PPC Description	3M v40 PPC Cost Weight
41	Post-Operative Hemorrhage & Hematoma w/ Hemorrhage Control Procedure or I&D	0.9745
42	Accidental Puncture/Laceration During Invasive Procedure	0.4264
47	Encephalopathy	0.7724
49	Iatrogenic Pneumothorax	0.4717
60	Major Puerperal Infection and Other Major Obstetric Complications	0.8978
61	Other Complications of Obstetrical Surgical & Perineal Wounds	0.2099
67	Pneumonia Combo (with and without Aspiration)	1.1332

Score & Revenue Adjustment Scale

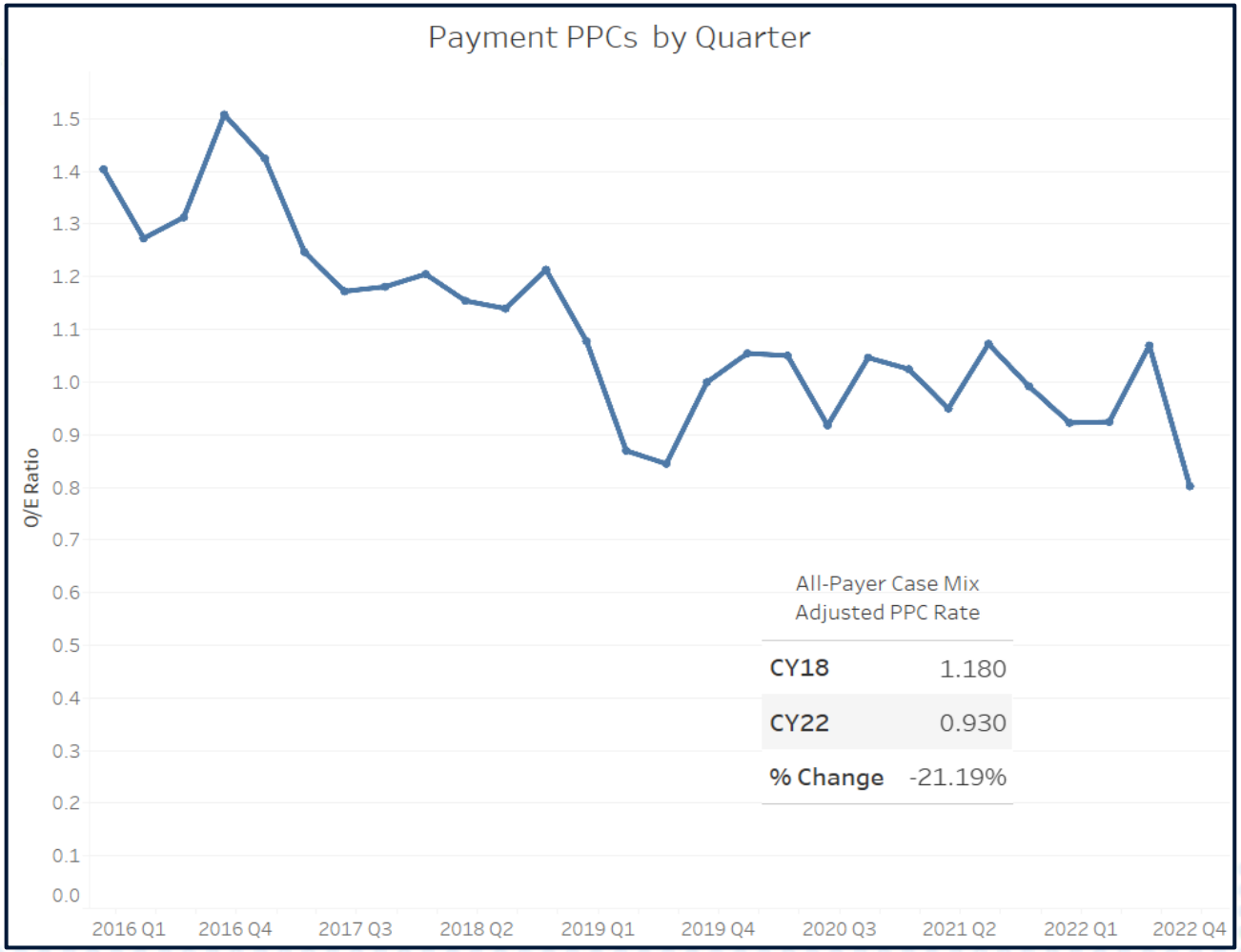
- The final score is calculated across all PPCs included for each hospital.
  - Sum numerator and denominator points to get percent score
- Scores and revenue adjustment scale range from 0% to 100%; scale has hold harmless zone between 60% and 70%.
  - Hold harmless zone determined from average/median score modeling
- Maximum penalty and reward is 2% of inpatient revenue.

The MHAC Summary report on the CRS portal provides PPC specific points, Hospital MHAC Scores, calculation sheet, and revenue adjustment scale.

Final MHAC Score	Revenue Adjustment
0%	**-2.00%**
5%	-1.83%
10%	-1.67%
15%	-1.50%
20%	-1.33%
25%	-1.17%
30%	-1.00%
35%	-0.83%
40%	-0.67%
45%	-0.50%
50%	-0.33%
55%	-0.17%
60%	0.00%
65%	0.00%
70%	0.00%
75%	0.33%
80%	0.67%
85%	1.00%
90%	1.33%
95%	1.67%
100%	**2.00%**
Penalty Cut-point	**60%**
Reward Cut-point	**70%**

RY 2025 Measurement Methodology Recap

- Evaluate hospital performance on PPCs
  - 15 included in payment program, others in monitoring for potential inclusion in future years
- Assess hospital performance on attainment from 0-100% with a revenue hold harmless zone between 60-70%
- Weight PPCs in payment program by 3M cost weights as a proxy for patient harm
- Maximum reward and penalty at 2%



Hospitals are exceeding the TCOC model goal to not backslide on PPC reductions gained under the All-Payer model.

Note: Based on V39 final data through December 2022

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QBR Methodology

Quality Based Reimbursement (QBR) Program

Purpose

To incentivize quality improvement across three patient-centered quality measurement domains:

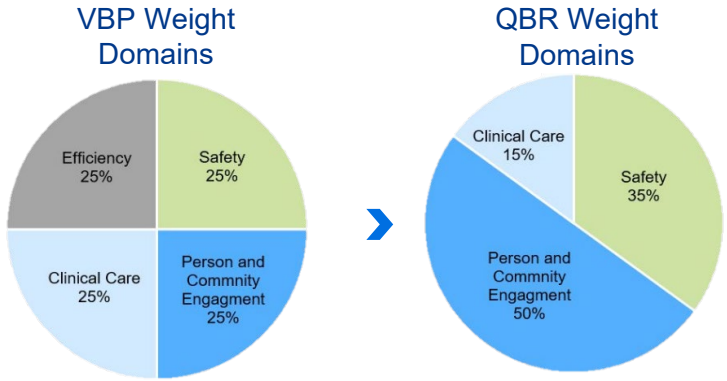
1. **Person and Community Engagement (HCAHPS)** - 8 survey-based measures + follow-up
2. **Clinical Care** - inpatient mortality rate + hip/knee replacement complication rate
3. **Safety** - 6 measures of in-patient Safety (National Healthcare Safety Network (NHSN) Healthcare Associated Infections) + Patient Safety Index (PSI-90)

How it Works: Revenue-at-Risk

The Program puts **2 percent** of inpatient hospital revenue at risk (maximum penalty/reward)

Federal Alignment

The QBR program uses **similar measures to the federal Medicare Value-Based Purchasing (VBP) program** but has an all-payer focus and can adjust domain weights to focus on MD-specific improvements.



Overview of QBR Methodology

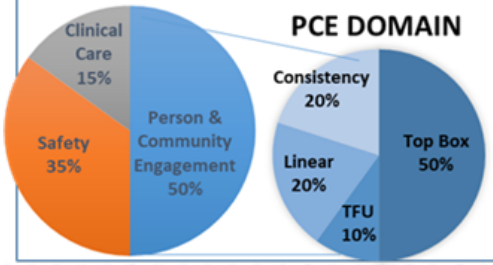
Performance measures

Measures by domain:

Person and Community Engagement (PCE)- follow-up after chronic conditions exacerbation measure (TFU) Medicare,
NEW add TFU Medicaid;
8 HCAHPS categories top box, 4 HCAHPS categories linear score.

Safety- (6 measures: 5 CDC NHSN HAI categories; all-payer PSI 90 measure)

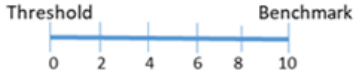
Clinical Care- (inpatient mortality, THA/TKA complications)



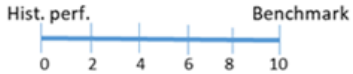
Standardized measure scores

Individual measures are converted to 0–10 points:

Points for attainment are based on performance versus a national threshold (median) and benchmark (top 5%)



Points for improvement are based on performance versus base (historical perf.) and benchmark



Final score is the better of the two scores (improvement or attainment)

Hospital QBR score and revenue adjustments

Hospital QBR score is the sum of earned points / possible points with domain weights applied

Scale of 0–80%

Max penalty -2% & reward +2%

Abbreviated Pre-Set Scale	QBR Score	Financial Adjustment
Max Penalty	0%	-2.00%
	10%	-1.51%
	20%	-1.02%
	30%	-0.54%
Penalty/Reward Cutpoint	41%	0.00%
	50%	0.46%
	60%	0.97%
	70%	1.49%
Max Reward	80%+	2.00%

QBR Methodology: Measure Inclusion Rules and Data Sources

- HSCRC will use the **data submitted to CMS for the Inpatient Quality Reporting** program for calculating hospital performance scores for all measures with exception of PSI-90 and the mortality measures, which are calculated using HSCRC case-mix data. The TFU measure is calculated using CCLF data.
- **Hospitals must have at least 100 HCAHPS survey/HCAHPS results** to be included in the program.
- For hospitals with measures that have **no base period data, attainment only scores** will be used to evaluate performance.
- Domain weighting is adjusted based on data availability (ie., if no safety score, PCE domain weighted at 77% and Clinical Care domain weighted at 23%)

It is imperative that hospitals review the data in the Care Compare Preview Reports as soon as it is available from CMS.

QBR Methodology: Measure Inclusion Rules and Data Sources

DOMAIN	Clinical Care	Person and Community Engagement*	Safety
Inclusion Criteria	Mortality: - **No minimum threshold** for hospitals - Statewide: **20 cases for APR-DRG cell** to be included THA/TKA: 25 cases for hospitals^	- At least **100 surveys** during performance period	- At least **three measures** needed to calculate hospital score - Each NHSN measure requires at least **one predicted infection** during the applicable period
Data Source	Mortality: HSCRC **Case-Mix Data** THA/TKA: CMS Hospital Compare	**HCAHPS surveys** reported to CMS Hospital Compare TFU: CCLF	**CDC- NHSN data** reported to CMS Hospital Compare PSI-90: HSCRC Case-Mix

***Must have PCE domain score to be included in QBR Program**
^Maryland: Hospital with less than 50 elective procedures over three years that are in the top 10th percentile of complexity as defined by average case mix index

RY 2025 Maryland Mortality Measure

- Maryland measures **inpatient** mortality, risk-adjusted for:
  - 3M risk of mortality (ROM)
  - Sex, age, and age-squared
  - Transfers from another acute hospital within MD
  - Palliative Care status
  - Confirmed COVID-19 flag
- Measure inclusion/exclusion criteria provided in calculation sheet.
  - Subset of APR-DRGs account for 80% of all mortalities.
  - Specific high mortality APR-DRGs and very low mortality APR-DRGs are removed.
- All-Payer
- Hospitals evaluated using **risk-adjusted survival rate**

Case- and Hospital-level reports provided on CRS portal monthly.

RY 2025 Timely Follow-up After Acute Exacerbations of Chronic Conditions

- NQF endorsed health plan measure that looks at percentage of ED, observation stays, and inpatient admissions for one of the following six conditions, where a follow-up was received within time frame recommended by clinical practice:
  - Hypertension (7 days)
  - Asthma (14 days)
  - Heart Failure (14 days)
  - CAD (14 days)
  - COPD (30 days)
  - Diabetes (30 days)
- COVID pts included
- Medicaid and Medicare FFS measured separately

Summary reports are posted to the CRS portal monthly. Case-Level reports are posted for Medicare only.

RY 2025 All-Payer Patient Safety Index

PSI-90 is composite measure of 10 AHRQ-specified PSIs of in-hospital complications and adverse events following surgeries, procedures, and childbirth:

- PSI 03 Pressure Ulcer
- PSI 06 Iatrogenic Pneumothorax Rate
- PSI 08 In-Hospital Fall with Hip Fracture Rate
- PSI 09 Perioperative Hemorrhage or Hematoma Rate
- PSI 10 Postoperative Acute Kidney Injury Requiring Dialysis Rate
- PSI 11 Postoperative Respiratory Failure Rate
- PSI 12 Perioperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) Rate
- PSI 13 Postoperative Sepsis Rate
- PSI 14 Postoperative Wound Dehiscence Rate
- PSI 15 Abdominopelvic Accidental Puncture or Laceration Rate

Case- and Hospital-level reports are posted to the CRS portal monthly.

QBR Scoring: Better of Attainment or Improvement

Attainment

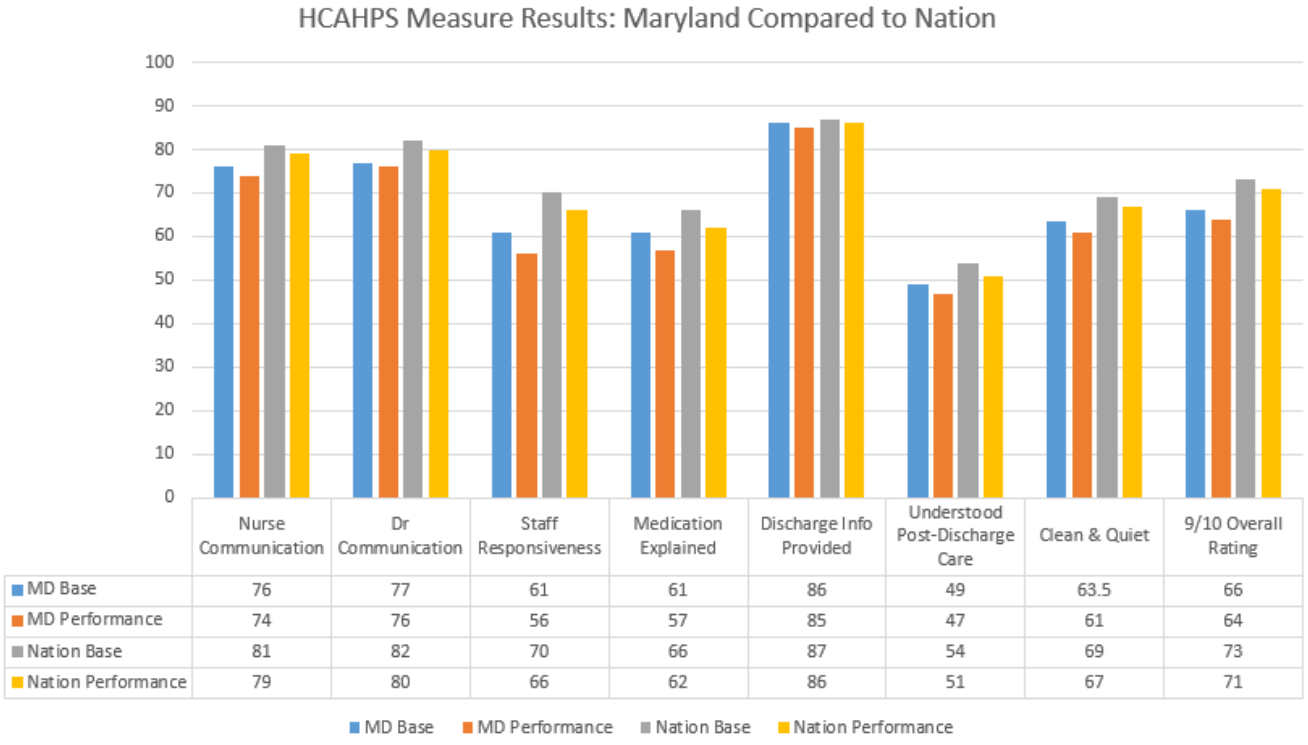
- compares hospital's rate to a threshold and benchmark.
- if a hospital's score is equal to or greater than the benchmark, the hospital will receive 10 points for achievement.
- if a hospital's score is equal to or greater than the achievement threshold (but below the benchmark), the hospital will receive a score of 1–9 based on a linear scale established for the achievement range.

Improvement

- compares hospital's rate to the base year (the highest rate in the previous year for opportunity and HCAHPS performance scores)

- if a hospital's score on the measure during the performance period is greater than its baseline period score but below the benchmark (within the improvement range), the hospital will receive a score of 0–9 based on the linear scale that defines the improvement range.

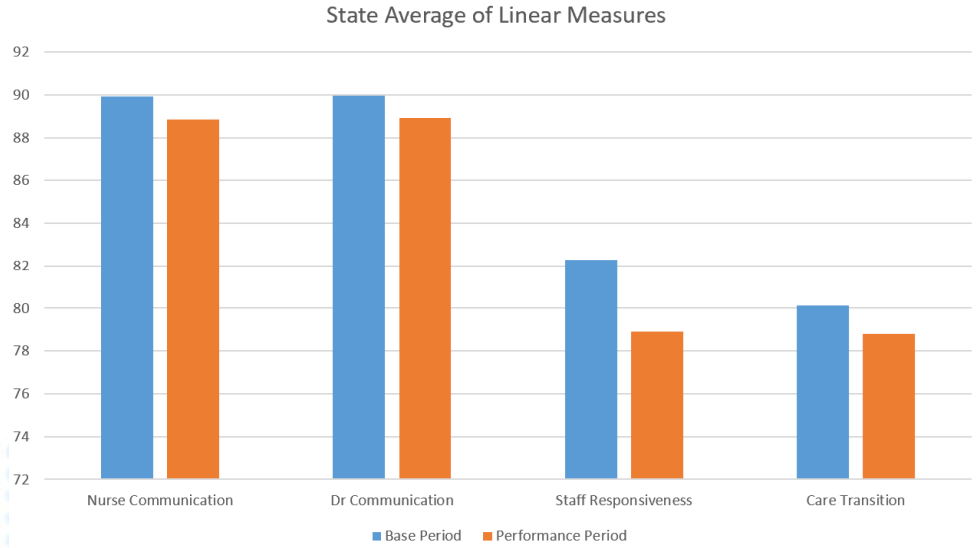
HCAHPS Performance: MD Compared to the Nation, Top-Box Scores, CY 2019 vs 7/1/21-6/30/22



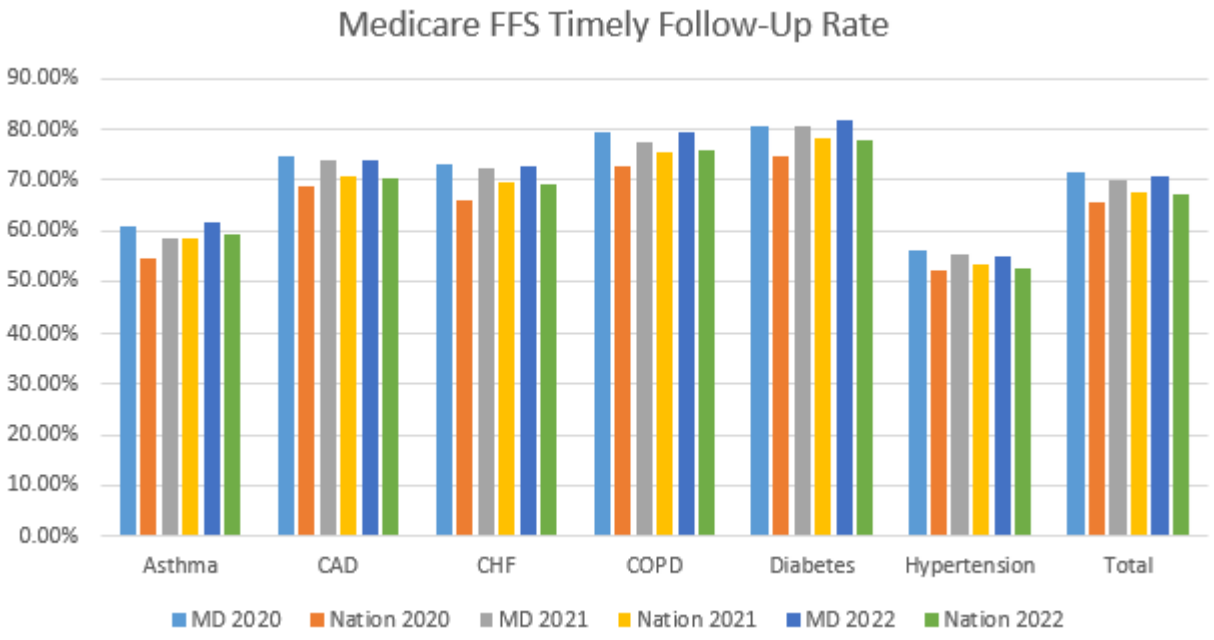
	Nurse Communication	Dr Communication	Staff Responsiveness	Medication Explained	Discharge Info Provided	Understood Post-Discharge Care	Clean & Quiet	9/10 Overall Rating
MD Base	76	77	61	61	86	49	63.5	66
MD Performance	74	76	56	57	85	47	61	64
Nation Base	81	82	70	66	87	54	69	73
Nation Performance	79	80	66	62	86	51	67	71

Linear Measure HCAHPS Results, CY 2019 vs 7/1/21-6/30/22

- In RY 2024, HCAHPS linear measure results were added to further incentivize focus on HCAHPS by providing credit for improvements along the continuum and not just improvements in top-box scores
- 20% of PCE domain (10% of overall QBR score)
- 4 measures chosen are correlated with other patient safety outcomes

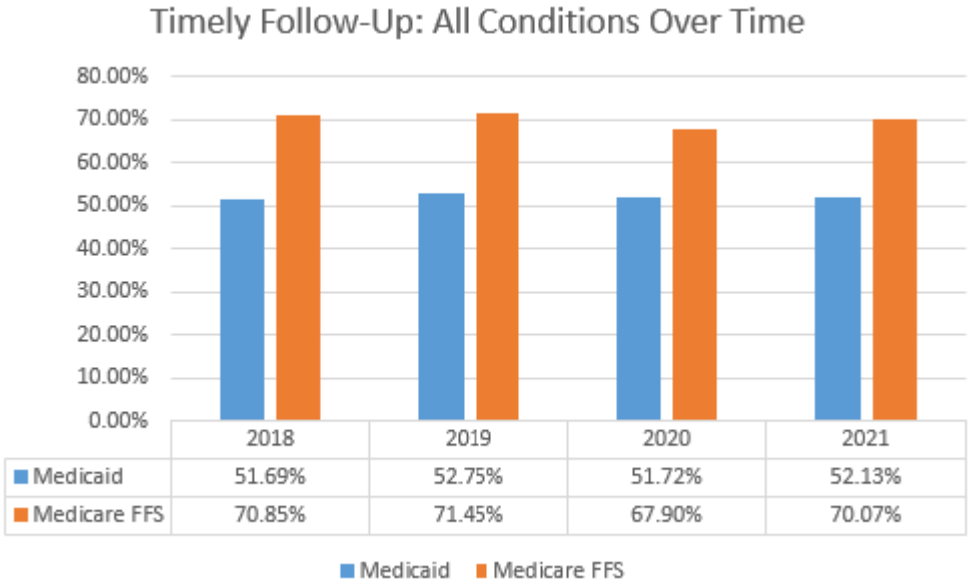


Medicare FFS TFU, CY 2020-2022

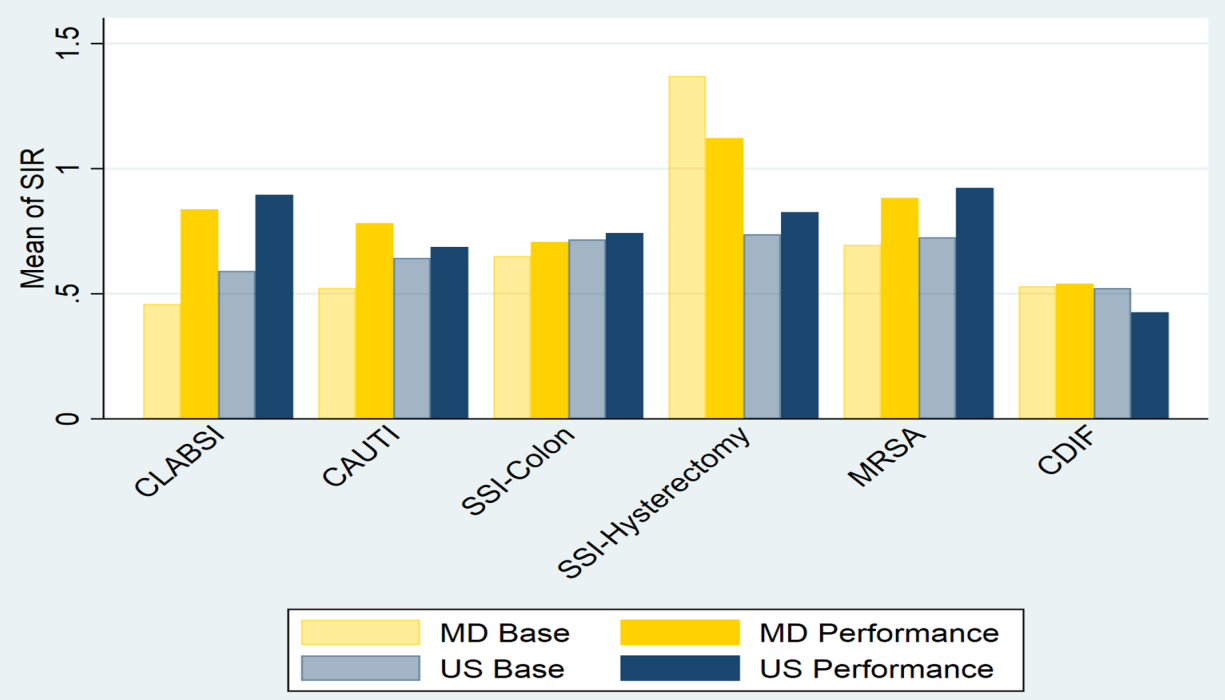


Medicaid TFU

- Beginning in RY 2025, Medicaid TFU rates were added to the QBR as 5% of the PCE domain (2.5% of overall QBR score)
- Added due to disparities between payers (Medicaid and Medicare)

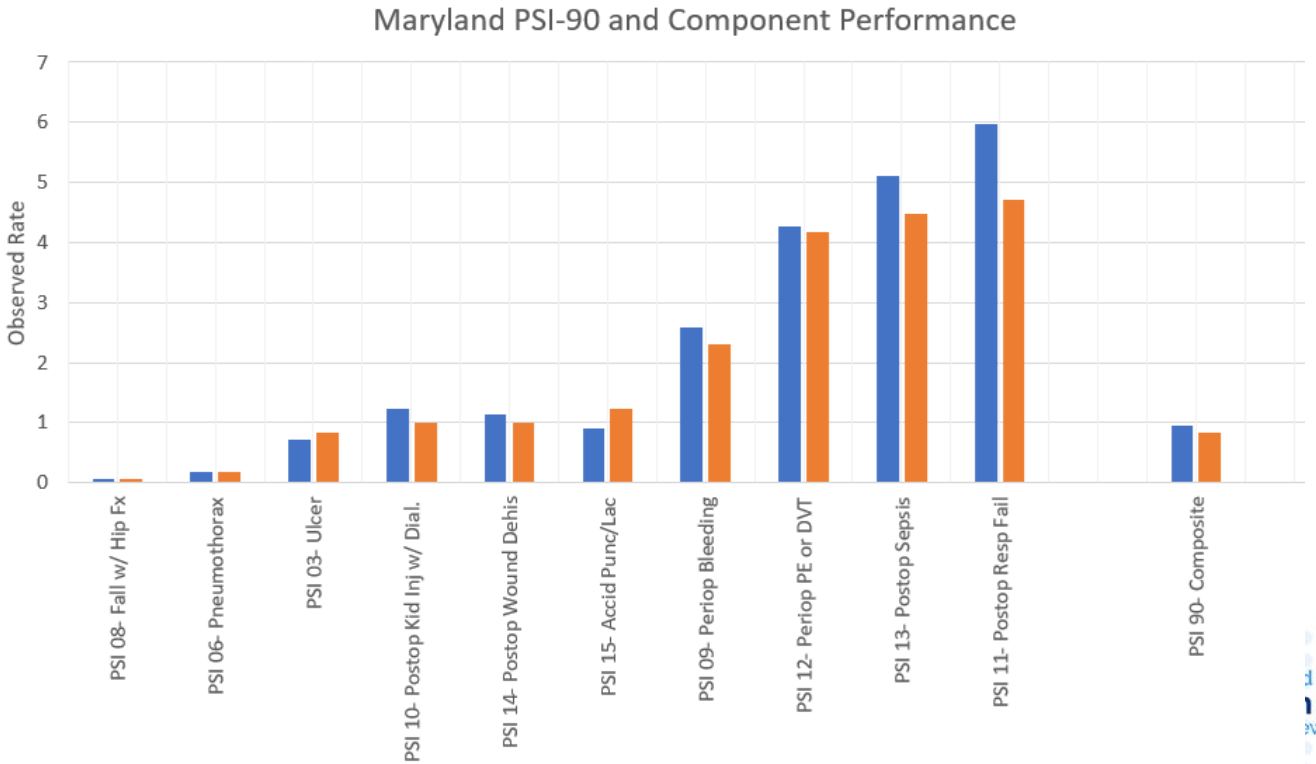


NHSN SIR Values for CY19 Compared CY2021Q3- CY2022Q2, Maryland vs. the Nation.

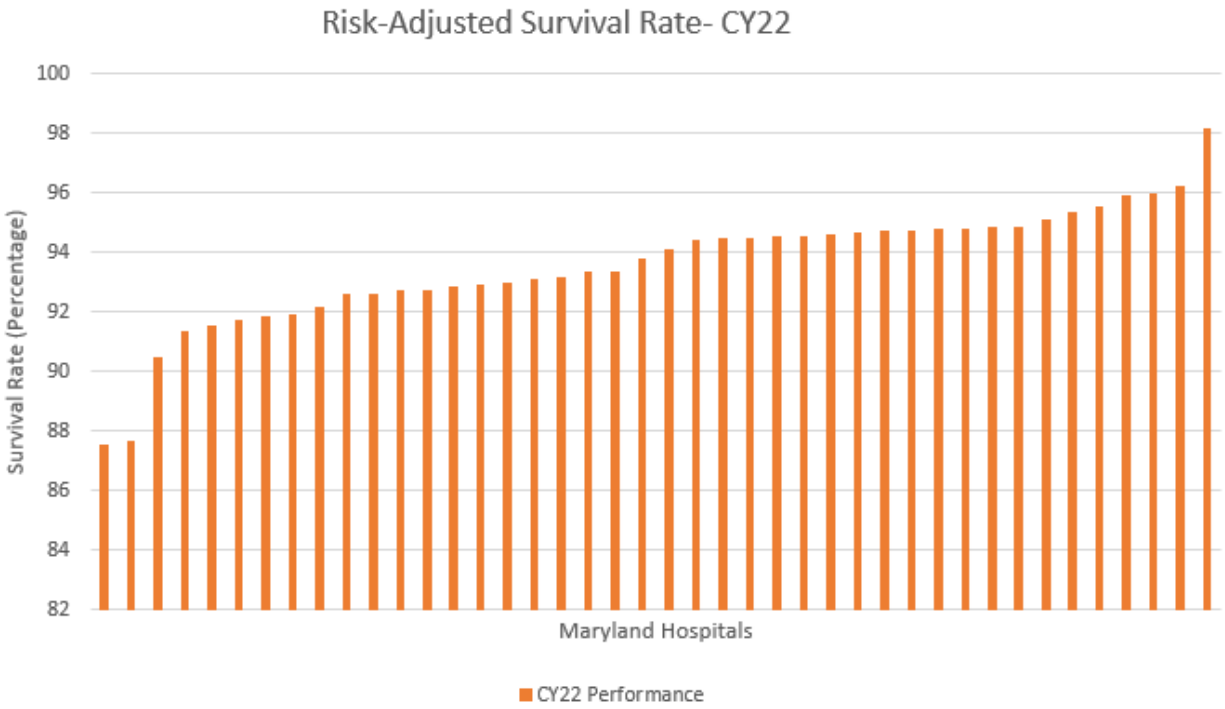


Maryland Statewide All-Payer Performance on PSI-90 and Component Indicators,

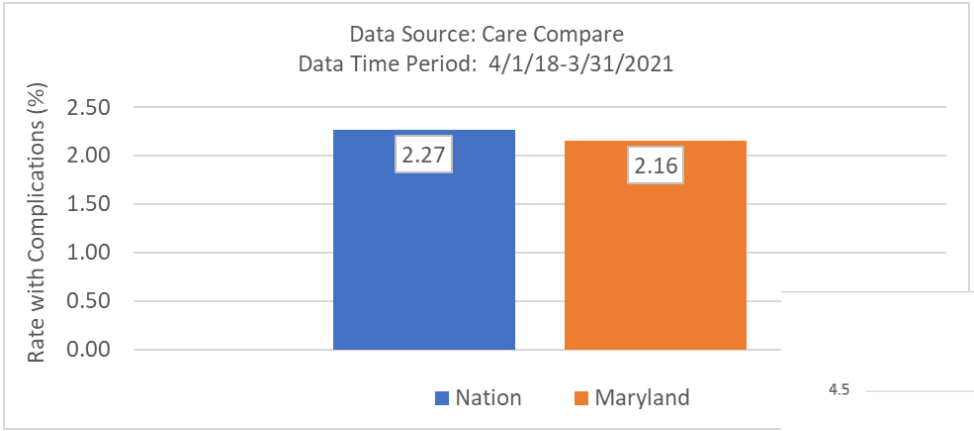
CY 2022 Compared to FY 2021 (July 2020-June 2021)

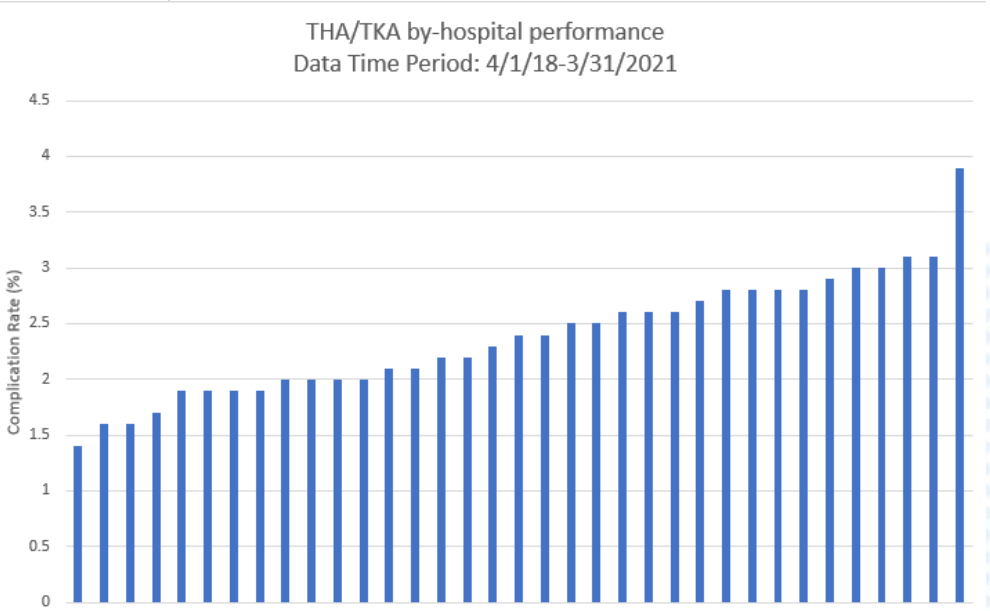


Hospital Level Performance, Mortality Measure



THA/TKA


Data Source: Care Compare
Data Time Period: 4/1/18-3/31/2021
Rate with Complications (%)
2.50
2.00
1.50
1.00
0.50
0.00
2.27
2.16
Nation
Maryland


THA/TKA by-hospital performance
Data Time Period: 4/1/18-3/31/2021
Complication Rate (%)
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0

Overall Score & Revenue Adjustment Scale

1. Assess performance on each measure in the domain
2. Standardize measure scores relative to performance standards
3. Calculate the total points a hospital earned divided by the total possible points for each domain
4. Finalize the total hospital QBR score (0 to 100 percent) by weighting the domains based on the overall percentage placed on each domain
5. Convert the total hospital QBR score into a revenue adjustment using the preset scale

Abbreviated Pre-Set Scale	QBR Score	Financial Adjustment
Max Penalty	**0%**	**-2.00%**
	10%	-1.51%
	20%	-1.02%
	30%	-0.54%
Penalty/Reward Cutpoint	41%	0.00%
	50%	0.46%
	60%	0.97%
	70%	1.49%
Max Reward	**80%+**	**2.00%**

RY 2025 Measurement Methodology Recap

- Measures are converted to 0-10 points using performance standards
- Final score is the better of attainment or improvement
- QBR Score: Sum of earned points/possible points with domain weights
- Preset Scale of 0-80%, with 41% cutpoint
- Max penalty and reward at 2%

- PCE Domain (50%)
  - HCAHPS top-box
  - HCAHPS linear
  - TFU- Medicare FFS
  - TFU- Medicaid ***NEW in RY 2025***
- Safety Domain (35%)
  - PSI-90
  - 6 NHSN HAI measures
- Clinical Care Domain (15%)
  - IP Mortality
  - THA/TKA

RRIP Methodology

RRIP and RRIP-Disparity Gap Methodology Overview

30-day, All-Cause Readmission Measure

Measure Includes:
Readmissions within 30 days of Acute Case Discharge:

- All-Payer
- All-Cause
- All-Hospital (both intra- and inter- hospital)
- Chronic Beds included
- IP-Psych and Specialty Hospitals included
- Adult oncology Discharges Included

Global Exclusions:

- Planned Admissions
- Same-day and Next-day Transfers
- Rehab Hospitals
- Discharges leaving Against Medical Advice Deaths

Case-Mix Adjustment

Performance Measure: CY 2023 Case-mix Adjusted Readmission Rate, adjusted for out-of-state readmissions (Attainment); Reduction in Case-mix Adjusted Readmission Rate from CY2018 Base Period (Improvement).

Case-mix Adjustment:
Expected number of unplanned readmissions for each hospital are calculated using the discharge APR-DRG and severity of illness (SOI).

*Observed Unplanned Readmissions / Expected Unplanned Readmissions * Statewide Readmission Rate*

CY2021 used to calculate statewide averages (normative values).

CY2018 (using CY21 norms) is base period and used to set the attainment benchmark/threshold.

Revenue Adjustments

Hospital RRIP revenue adjustments are based on the better of attainment or improvement, scaled between the Max Reward and Max Penalty.

Scores Range from Max Penalty -2% & Reward+2%

All Payer Readmission Rate Change CY18-23		% IP Revenue Payment Adjustment
	A	B
Improving		2.0%
	-28.50%	2.00%
	-23.25%	1.50%
	-18.00%	1.00%
	-12.75%	0.50%
Target	-7.50%	0.00%
	-2.25%	-0.50%
	3.00%	-1.00%
	8.25%	-1.50%
	13.50%	-2.0%
Worsening		-2.0%

Improvement

Attainment

All Payer Readmission Rate CY23		RRIP % Inpatient
Lower Readmission Rate		2.0%
Benchmark	8.15%	2.00%
	9.74%	1.00%
Threshold	11.32%	0.00%
	12.90%	-1.00%
	14.49%	-2.00%
Higher Readmission Rate		-2.0%

Readmissions Reduction Incentive Program (RRIP)

Purpose

To incentivize hospitals to reduce avoidable readmissions by linking payment to (1) improvements in readmissions rates, and (2) attainment of relatively low readmission rates.

- **What is a readmission?** A readmission occurs when a patient is discharged from a hospital and is subsequently re-admitted to any hospital within 30 days of the discharge.
- **Why focus on readmissions?** Preventable hospitals readmissions may result from complications from previous hospitalizations or inadequate care coordination following discharge and can lead to substandard care quality for patients and unnecessary costs.

How it Works: Revenue-at-Risk

The program puts **2 percent** of inpatient hospital revenue at risk (maximum penalty/reward) + 0.5 percent max disparity gap reward

Federal Alignment

The RRIP is **similar to the Medicare Hospital Readmissions Reduction Program (HRRP)**, but has an all-payer focus.

Performance Metric

- Case-Mix Adjusted Inpatient Readmission Rate
  - 30-Day
  - All-Cause, All-Payer
  - All-Hospital (both intra- and inter- hospital)
  - Chronic beds and readmissions to specialty hospitals included
- Exclusions:
  - Same-day and next-day transfers
  - Rehabilitation Hospitals
  - Pediatric Oncology discharges
  - Planned readmissions – CMS Planned Readmission Logic (v4 2022), rehab and OB deliveries
  - Deaths, Left AMA
- Adjustments
  - APR-DRG SOI

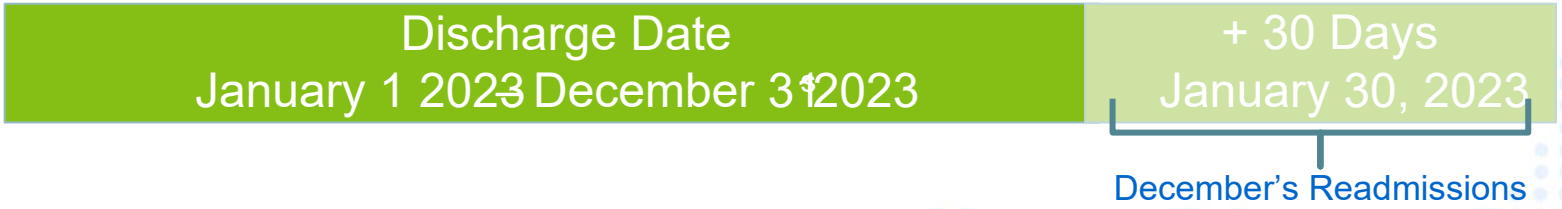
Summary and case-level* reports are posted to the CRS portal monthly.

*Patients who opt-out of CRISP data-sharing and/or experience SUD are excluded from patient-level reports

Data Sources and Timeframe

- Inpatient abstract/case mix data with CRISP Unique Identifier (EID).
  - Base period: CY 2018 (using CY21 norms)
  - Normative period: CY 2021 (post COVID)
  - Performance period: CY 2023
  - v40 of the APR grouper
- Data on out of state readmissions is obtained from Medicare and used to adjust the all-payer readmission rate
- Looks 30-days after the performance period

Example CY 2023



Case-Mix Adjustment

- Hospital performance is measured using the Observed (O) unplanned readmissions / Expected (E) unplanned readmission ratio and multiplying by the statewide base period readmission rate.

- Expected number of unplanned readmissions for each hospital are calculated using the discharge APR-DRG and severity of illness (SOI).

Measuring the Better of Attainment or Improvement

- The RRIP continues to measure the better of attainment or improvement due to concerns that hospitals with low readmission rates may have less opportunity for improvement.
- RRIP adjustments are scaled, with maximum penalties up to 2% of inpatient revenue and maximum rewards up to 2% of inpatient revenue.

Rate Year	Performance Year	Improvement Target (from CY 2018)	Attainment Reward Threshold
RY 2025	CY 2023	7.50%	11.32%*

Attainment threshold is 65th percentile of readmission rate in 2018, further adjusted for out-of-state readmissions

Improvement Scaling

- Improvement compares CY23 case-mix adjusted inpatient readmission rates to CY18 case-mix adjusted inpatient readmission rates
- Improvement Target for CY23 = 7.50% cumulative decrease
- Adjustments range from 2% reward to 2% penalty, scaled for performance

All Payer Readmission Rate Change CY18-23	RRIP % Inpatient Revenue Payment Adjustment
A	B
Improving Readmission Rate	2.0%
-28.50%	2.00%
-23.25%	1.50%
-18.00%	1.00%
-12.75%	0.50%
-7.50%	0.00%
-2.25%	-0.50%
3.00%	-1.00%
8.25%	-1.50%
13.50%	-2.0%
Worsening Readmission Rate	2.0%

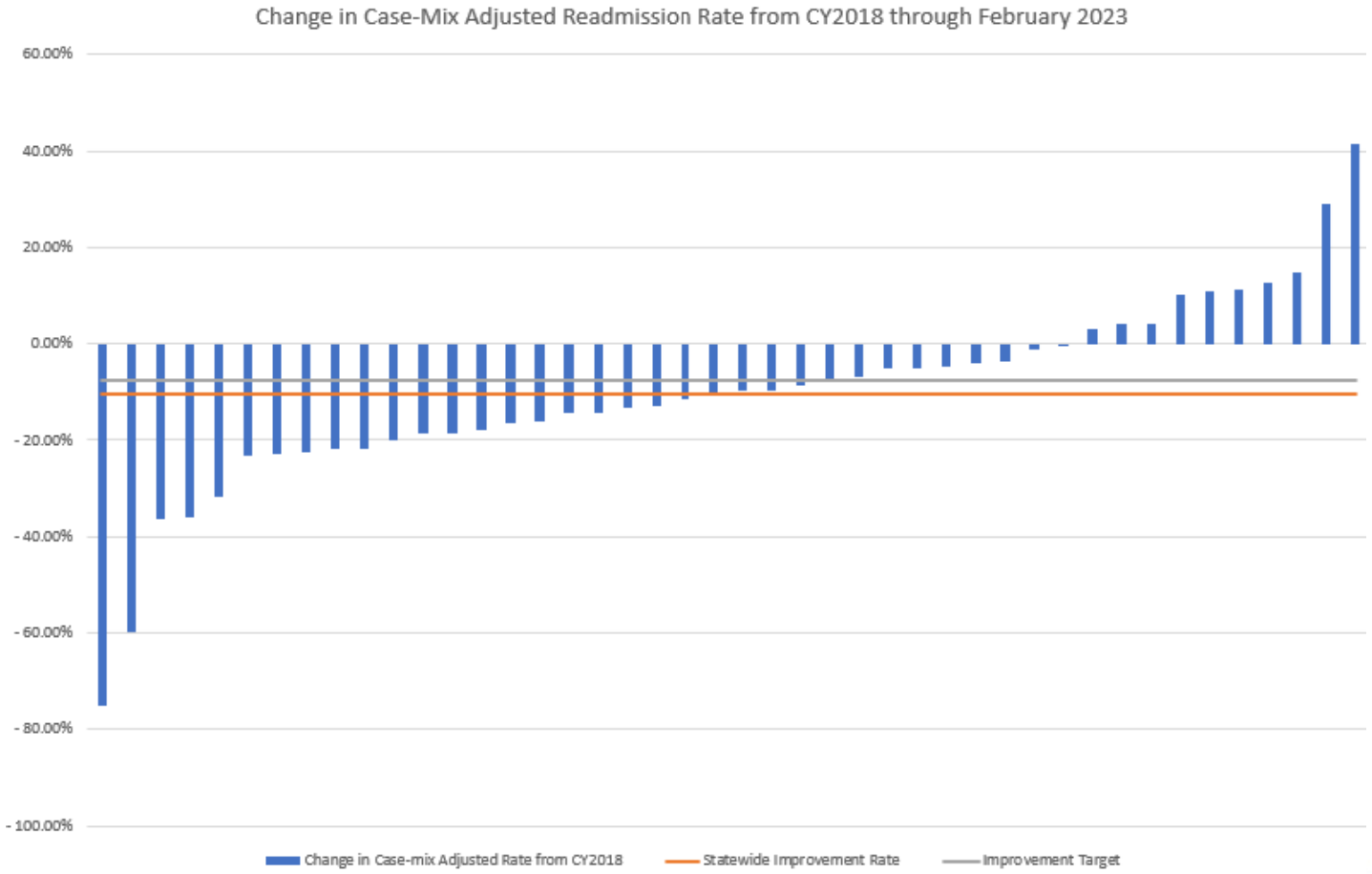
Attainment Scaling

- Attainment scaling compares CY23 case-mix adjusted inpatient readmission rates to a state threshold (65th percentile of 2018 readmission rates)
  - Attainment scores adjusted to account for readmissions occurring at non-Maryland hospitals (OOS adjustment)
- Attainment Benchmark for CY23= 11.32%
- Adjustments range from 2% reward to 2% penalty, scaled for performance

All Payer Readmission Rate CY23	RRIP % Inpatient Revenue Payment Adjustment
LOWER	2.0%
8.15%	2.0%
8.47%	1.80%
8.79%	1.60%
9.10%	1.40%
9.42%	1.20%
9.74%	1.00%
10.05%	0.80%
10.37%	0.60%
10.69%	0.40%
11.00%	0.20%
11.32%	0.00%
11.64%	-0.20%
11.95%	-0.40%
12.27%	-0.60%
12.59%	-0.80%
12.90%	-1.00%
13.22%	-1.20%
13.54%	-1.40%
13.85%	-1.60%
14.17%	-1.80%
14.49%	-2.00%

RY 2025 Measurement Methodology Recap

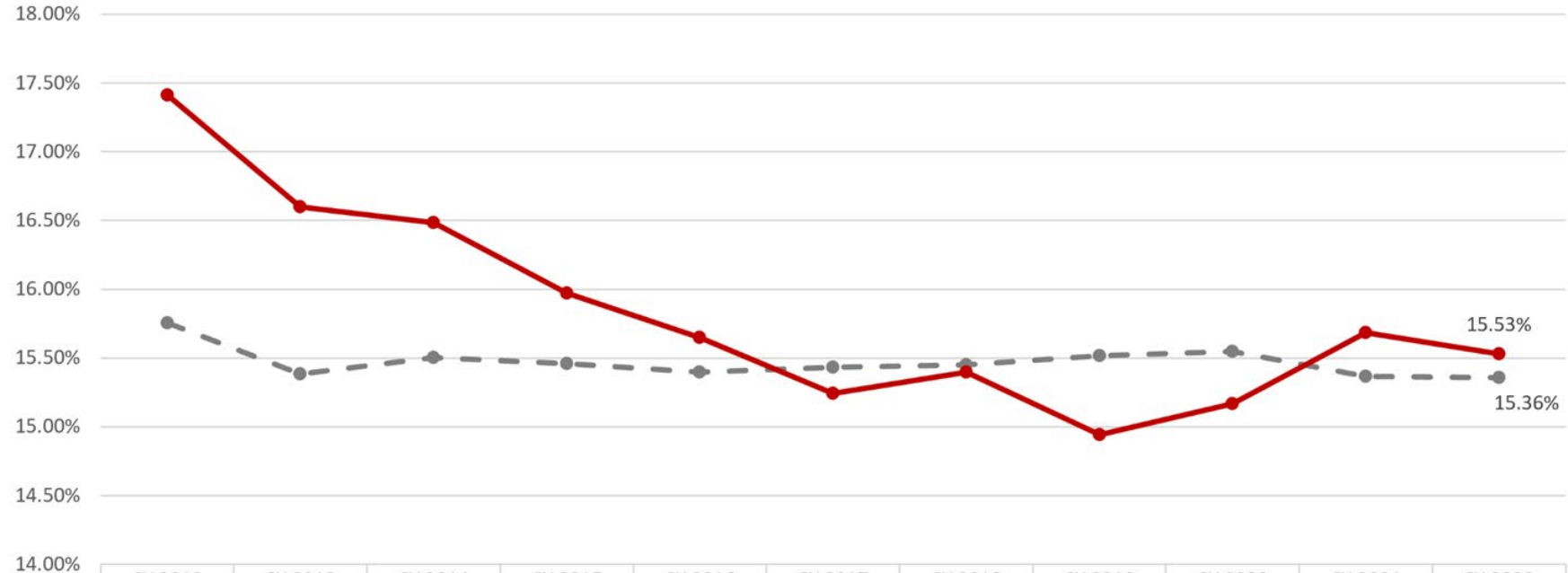
- Performance Metric: Case-mix adjusted readmission rates
- Case-mix adjustment:
  - Observed Unplanned Readmissions / Expected Unplanned Readmissions * Statewide Readmission Rate
- Readmissions targets: Better of improvement or attainment
  - Improvement – 7.50% Improvement target; max 2% reward at 28.50% improvement
  - Attainment – 11.32% Attainment target; max 2% reward at 8.15% rate



State on track to meet goal of 7.50% improvement in readmissions compared to CY 2018

maryland health services cost review commission

Readmissions - Rolling 12M through December 2022



	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
National	15.76%	15.38%	15.50%	15.46%	15.40%	15.43%	15.45%	15.52%	15.55%	15.37%	15.36%
Maryland	17.41%	16.60%	16.48%	15.97%	15.65%	15.24%	15.40%	14.94%	15.17%	15.68%	15.53%

RRIP-Disparity Gap Methodology

The RRIP's Disparities Component

The Readmissions Reduction Incentive Program includes a **within-hospital disparities readmissions measure,** making it the **only statewide program in the nation** with an **incentive for reducing disparities in all-payer readmission rates.**

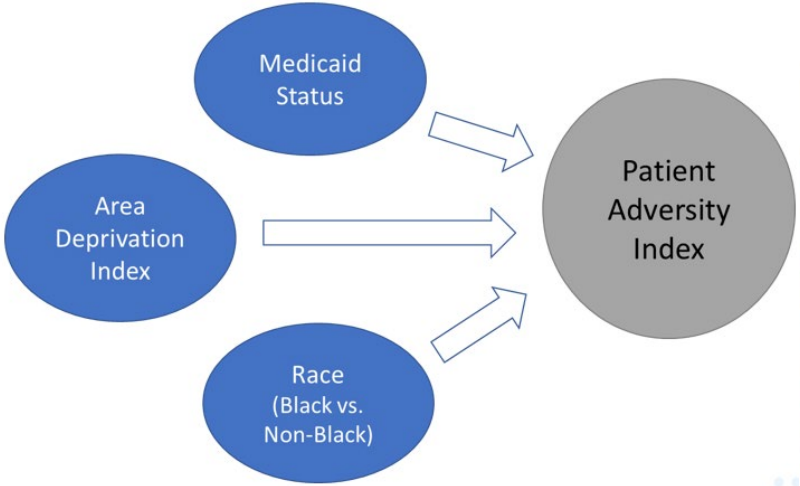
HSCRC rewards hospitals with reductions in year-over-year overall readmission rate disparities related to race and socioeconomic status, with the goal of a 50% reduction in disparities over 8 years.

Rewards are scaled

- Rewards are based on performance in 2018
- Rewards begin at 0.25% IP revenue for hospitals on track for 50% reduction in the disparity gap measure over 8 years.
- Rewards are capped at 0.50% of IP revenue for hospitals on pace for a 75% or larger reduction in the disparity gap measure over 8 years

Patient Adversity Index (PAI) Measurement

- HSCRC- developed claims-based measure
- Calculated for each discharge based on social factors:
  - Medicaid status (Yes or No)
  - Race (Black or Non-Black)
  - Area Deprivation Index (ADI), measure of neighborhood disadvantage
- Social factors weighted to reflect the strength of its association with readmissions
- Larger value = higher adversity
- PAI value is normalized so that statewide mean is 0. Each 1-point change in the scale represents a change of one standard deviation.

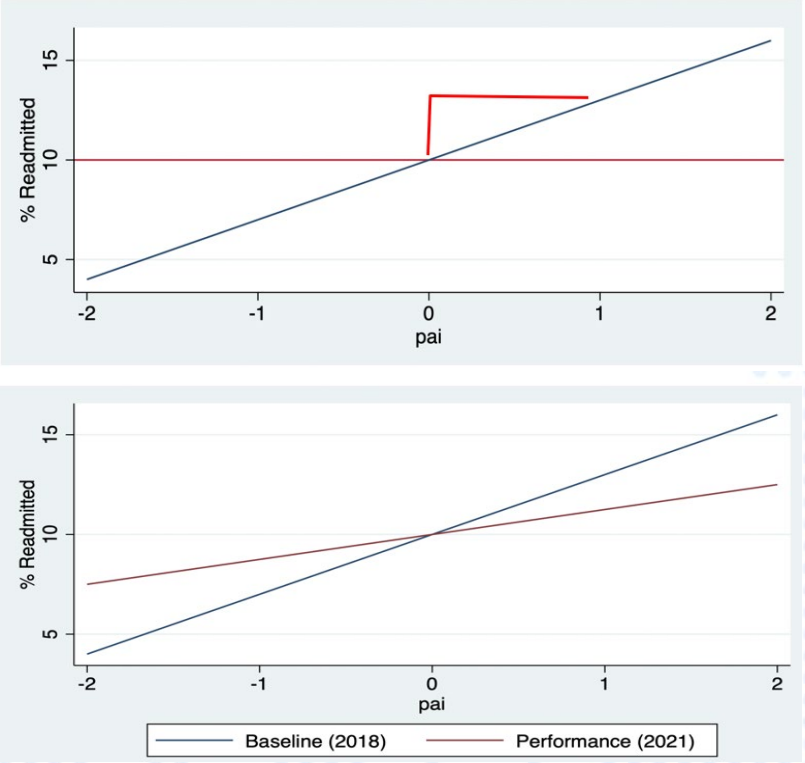


Performance Metric- Readmissions Disparity Gap Improvement

Disparity gap: reflection of how readmission risk within a hospital changes for patients with varying levels of PAI

- Estimates the change in readmission rates per one-unit change in PAI at each hospital
- Adjustments made based on:
  - Age
  - APR-DRG
  - Gender
  - Mean PAI value at the hospital (to avoid penalizing hospitals that serve higher proportions of high PAI/highly disadvantaged patients)

Hospital payments are based on the percent change of the disparity gap between the base period (2018) and performance period (2023).

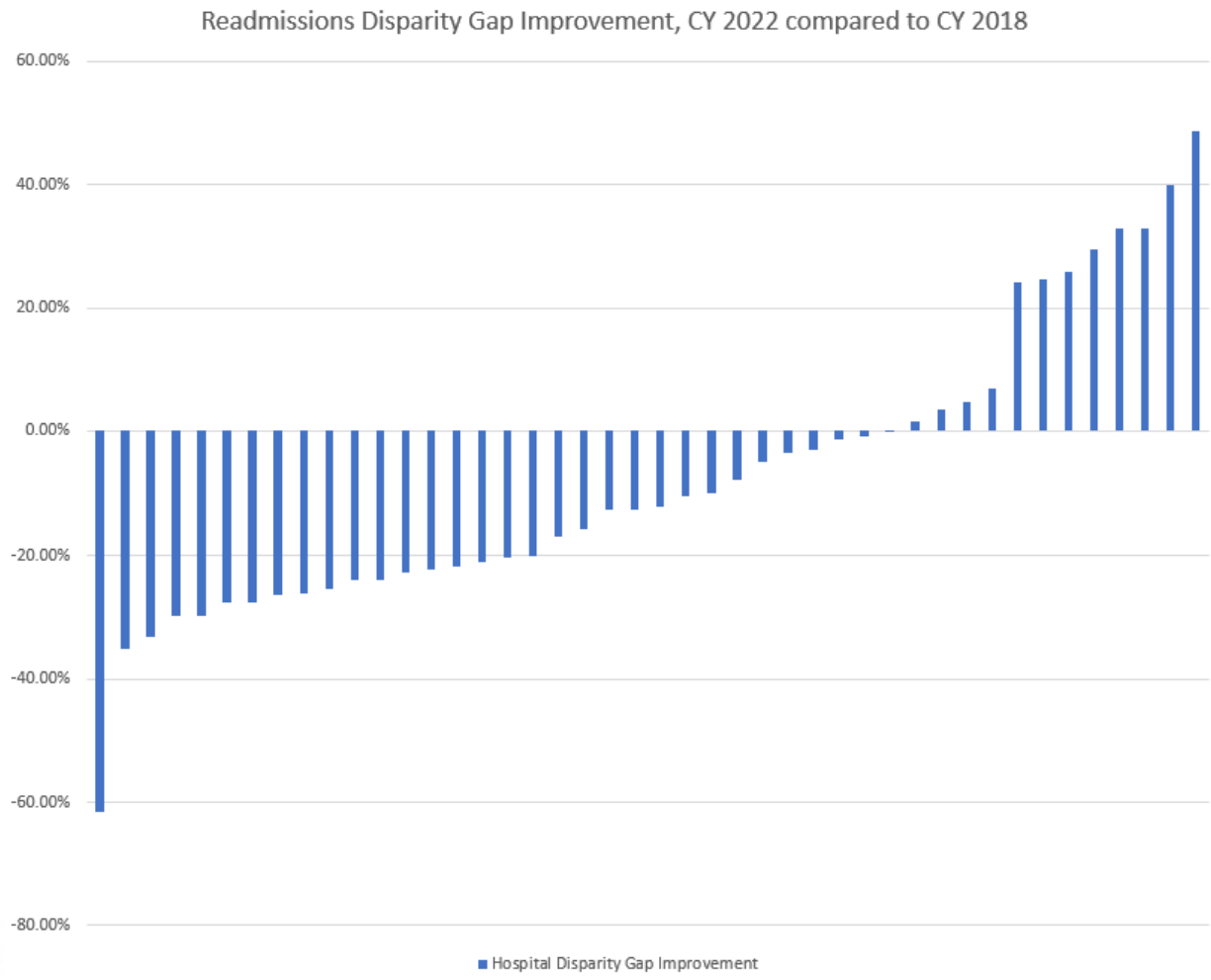


RY 2025 Readmissions Disparity Gap Scaling

- Assesses improvement only
- Model Goal: At least 50% of hospitals reduce their disparities in readmissions by 50% by RY2029
- CY 2023 performance standards: -29.29% threshold to begin rewards, -50% for full reward
- Reward-only
- Rewards scaled up to .50% of IP revenue

RY 2025 Measurement Methodology Recap

- Performance metric: % change in disparity gap comparing CY 2023 to CY 2018
- Begin receiving rewards at **29.29% reduction** in readmission disparities compared to CY 2018


Readmissions Disparity Gap Improvement, CY 2022 compared to CY 2018
60.00%
40.00%
20.00%
0.00%
-20.00%
-40.00%
-60.00%
-80.00%
Hospital Disparity Gap Improvement

RY 2024 Potentially Avoidable Utilization (PAU) Savings Policy

Potentially Avoidable Utilization (PAU) Savings Program

Purpose

- To encourage hospitals **to focus on improved care coordination and enhanced community-based care** by holding hospitals accountable for potentially avoidable utilization
- Designed to encourage hospitals to look at **upstream, community-based factors** that influence utilization

How it Works

"Potentially avoidable utilization" is defined as hospital care that is unplanned and may be prevented through improved care quality, care coordination, or effective community-based care

Methodology

The HSCRC examines the following measures in its PAU calculations:

- **30-day readmissions (uses similar logic as RRIP)** – All Hospital All Cause 30-Day Readmissions with adjustment for planned admissions
- **Avoidable admissions** – Ambulatory-care sensitive conditions identified with AHRQ Prevention Quality Indicators (PQIs) and Pediatric Quality Indicators (PDIs) (e.g. admissions for diabetes complications, admissions for urinary tract infections)

Purpose of PAU Savings and Overview

- PAU Savings Concept
  - The Global Budget Revenue (GBR) system assumes that hospitals will be able to reduce their PAU as care transforms in the state
  - The PAU Savings Policy prospectively reduces hospital GBRs in anticipation of those reductions
- Mechanism
  - Statewide reduction is scaled for each hospital based on avoidable admission rates and readmission revenue linked to the hospital in a prior year

RY2024 PAU Measures

Per Capita Prevention Quality Indicators (PQIs) and Pediatric Quality Indicators (PDIs)
•**Measure definition:** AHRQ Prevention Quality Indicators, which measure adult (18+) ambulatory care sensitive conditions. AHRQ Pediatric Quality Indicators focuses on preventable hospitalizations among pediatric patients •**Data source:** Inpatient and observation stays >= 24 hours
Revenue from PAU Readmissions
•**Measure definition:** 30-day unplanned readmissions measured at the sending hospital •See next slide for methodology •**Data Source:** Inpatient and observation stays >= 24 hours

RY2024 PAU Readmissions

- For RY2024 staff plans to maintain the readmission measure used under the RY2020 PAU Savings Policy
  - PAU Readmissions revenue are associated with the sending hospital, rather than the receiving hospital
  - To calculate the readmissions revenue associated with the sending hospital:
    - Calculated the average cost of an intra-hospital readmission (to and from the same hospital)
    - Apply the average cost to the total number of sending discharges from that hospital which resulted in non-PQI readmission

PAU reduction: Express as incremental

- Starting in RY2020, changed how PAU reduction is expressed in the update factor
  - Previously reversed out previous year's PAU reduction and implemented current year PAU reduction
  - Starting in RY20, calculating and displaying the incremental change only
- Use the inflation and population adjustments of the update factor to determine the statewide PAU reduction (i.e., do not provide inflation or population adjustments on PAU revenue)

Statewide PAU Savings Calculation

Table 1. Calculation of Statewide PAU Reduction

Calculation of Statewide Reduction	Formulas
Total Permanent Revenue in Previous Rate Year	A
Inflation Factor + Volume Adj. for Upcoming Rate Year	B
Total Experienced PAU $ in Previous Performance Year (CY)	C
Required Revenue Reduction $	D = B*C
Required Revenue Reduction %	E=D/A
Adjusted Rounded Statewide Revenue Reduction Value%	**F = Round(E,4)**
Adjusted Required Revenue Reduction $	**G = F*A**
Total PAU %	H
Total PAU $	I = A*H
Required Percent Reduction PAU	J = G/I

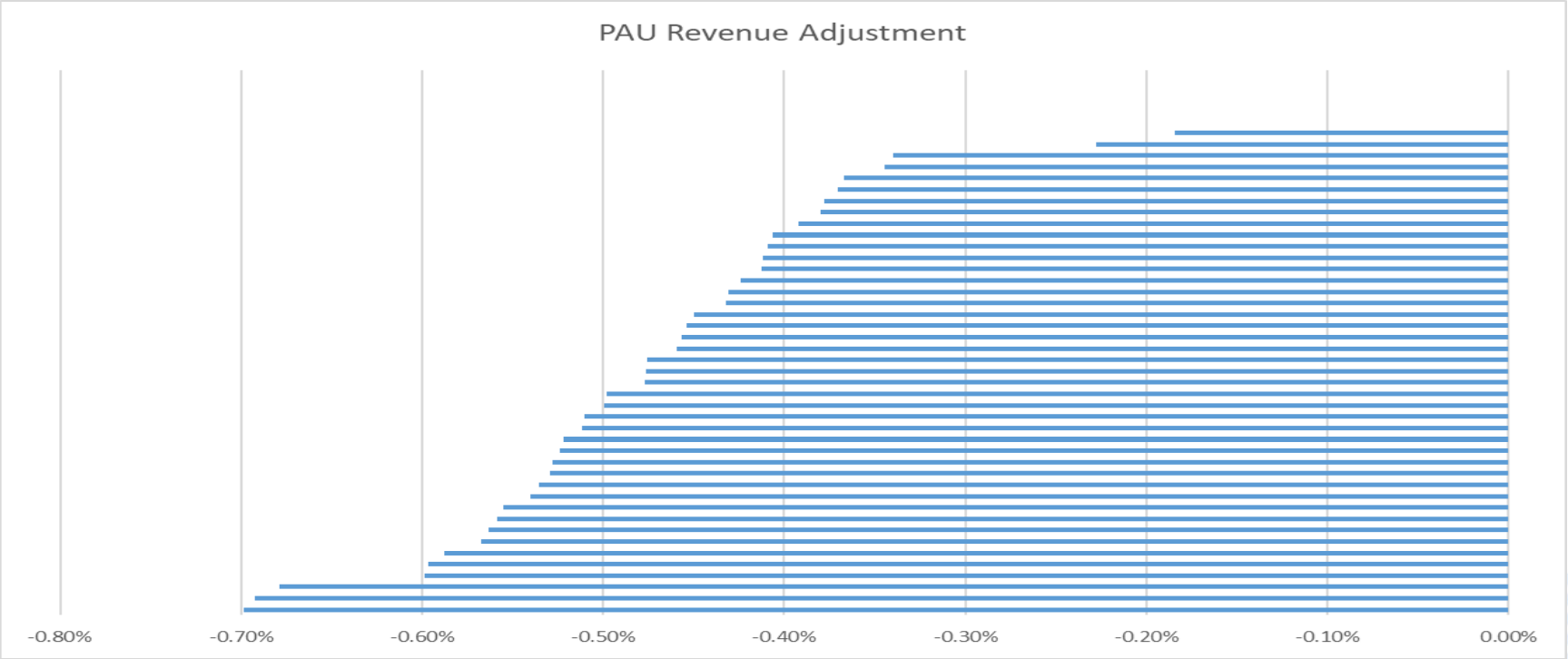
Table 2. Calculation of PAU Savings Domain Weights

PAU Savings Domains	PAU Revenue	PAU Domain Weights (%)	PAU Reduction (%)	PAU Reduction ($)
Avoidable Admissions	K	M = K/C	O = M*F	Q = M * G
Non-PQI Readmissions	L	N = L/C	P = N*F	R = N * G
Total Experienced PAU $	K + L = C	M + N = 100%	O + P = F	Q + R = G

Hospital-Specific PAU Savings

VALUES	FORMULAS
Hosp ID	A
Hospital Name	B
Permanent Total Revenue	C
Avoidable Admissions Performance	D
Avoidable Admissions Reduction	E = D / Statewide Total D * Adjusted proposed required revenue reduction % (F in Previous Slide) * Avoidable Admissions (PQIs and PDIs) Domain Weight (M in previous slide)
Avoidable Admission Adjustment $	F = E*C
Avoidable Admissions Adjustment $(Normalized)	G = F * (Adjusted proposed required revenue reduction (G in previous slide) * Avoidable Admissions (PQIs and PDIs) Domain Weight (M in previous slide)) / Statewide Total F
CY22 Readmissions %	H
PAU Readmissions Adjustment %	I = H / Statewide Total H * Adjusted proposed required revenue reduction % (F in Previous Slide) * Readmissions Domain Weight (N in previous slide)
PAU Readmissions Adjustment $	J = I*C
PAU Readmissions Adjustment $ (Normalized)	K = J * (Adjusted proposed required revenue reduction (G in previous slide) * Readmissions Domain Weight (N in previous slide)) / Statewide Total J
PAU reduction $	L = G+K
PAU reduction %	M = L/C

RY 2024 PAU Revenue Adjustments



Total Penalties	-$95,969,711
% Permanent Revenue	-0.49%

RY 2025 Maximum Guardrail under Maryland Hospital Performance-Based Programs

Final Recommendations for RY 2025

RY 2025 Quality Program Revenue Adjustments	Max Penalty	Max Reward
MHAC	-2.0%	2.0%
RRIP	-2.0%	2.0%
QBR	-2.0%	2.0%

- Percent of ***Maryland Medicare revenue at-risk for quality (6%)*** multiplied by the percent of ***Maryland revenue attributable to inpatient services***
- RY 2025 Guardrail: 6% x 58%* = 3.48%
- The quality adjustments are applied to inpatient revenue centers, similar to the approach used by CMS.
- RRIP-Disparity Gap is not included to encourage focus on and express the importance of advancing health equity

*CY2022 % IP Services

Digital Measures Reporting Requirements

Detailed reporting and submission information may be found on the CRISP website

Digital Measures Reporting: Measures

Reporting Period/ payment determination	CMS Measures	Maryland Measures
CY 2022/ FY 2024	Three self-selected eCQMs plus -Safe Use Opioids	Four eCQMs: Two self-selected eCQMs Two required measures: -Safe Opioids -ED-2
CY 2023/ FY 2025	Three self-selected eCQMs plus Safe Use Opioids Concurrent Prescribing Clinical data elements for two hybrid measures (beginning July 2023) -30-day mortality -30-day readmissions	Six required eCQMs: -Safe Opioids -ED-2 -hyperglycemia -hypoglycemia -Cesarean Birth -Severe Obstetric complications Clinical data elements for two hybrid measures (beginning July 2023) -30-day mortality -30-day readmissions

Digital Measures Reporting: Timeline

Data Submission Due Dates

CY 2023 Performance Period Submission Windows for eCQMs

Q1- 2023 data	Open: 07/15/2023	Close: 10/02/2023
Q2- 2023 data	Open: 07/15/2023	Close: 10/02/2023
Q3- 2023 data	Open: 10/15/2023	Close: 12/30/2023
Q4 2023 data	Open: 01/15/2024	Close: 04/01/2024

CY 2023 Performance Period Submission Windows for Hybrid ClinicalData Elements

Q3 2023 data	Open: 01/15/2024	Close: 04/01/2024
Q4 2023 data	Open: 01/15/2024	Close: 04/01/2024

CY 2023 Monitoring Reports

Monitoring Measures Update

- 30-Day All-Cause Mortality- death occurs up to 30 days post hospital discharge
- Excess Days in Acute Care (EDAC)- excess days that a hospital's patients spent in acute care within 30 days after discharge (ED visits, Obs stays, unplanned readmissions)
- Medicare TFU disparity gap measure- applying PAI to Medicare TFU measure
- Develop Timely Follow Up after a Behavioral Health Encounter measure
- Emergency Department Dramatic Improvement Effort (EDDIE)

Inpatient Diabetes Screening Measure Definition

- Numerator: # of inpatients with a CRISP A1c record with admit date <= service date <= discharge date
- Denominator: # of inpatient discharges patient in monitoring period
- Exclusions
  - <35 years old
  - Died in hospital
  - Transferred
  - AMA

Inpatient Diabetes Screening Policy Update

- Policy is currently in monitoring status
- Staff will evaluate transition to payment policy at end of CY23
- CRISP and HSCRC evaluated use of hospital lab feeds to track increases in IP A1c screening
- Hospital-level reporting now available in CRISP portal
- Working w/ CRISP on patient-level reporting
- Hospitals should confirm accuracy of A1c reporting in LOINC feeds to CRISP

Avoidable ED Utilization Measure Update

- Measure focuses on reducing utilization by multi-visit patients
- Currently in monitoring status
- Staff will evaluate transition to payment policy at end of CY23
- Numerator: # of ED visits at a given hospital by patients who have >= 4 visits at any hospital in calendar year
- Denominator: # of ED visits at a given hospital
- Hospital-level reporting currently available on CRISP portal
- Staff working w/ CRISP on patient-level report

Sample Report

hospid	name	Visit Count, All ED Patients, 12 months ending 03/31/2023	Visit Count, MVPs, 12 months ending 03/31/2023	% Visits by MVPs, 12 months ending 03/31/2023	Percent Change from Base
210000	Statewide	2054629	524714	25.54	0.63
210001	Meritus	66178	16967	25.64	1.75
210002	UMMC	50574	22137	43.77	0.9
210003	UM-Capital Region Medical Center	37497	6798	18.13	-1.15
210004	Holy Cross	64260	11309	17.6	3.53
210005	Frederick	70242	13938	19.84	1.54
210006	UM-Harford	20435	5675	27.77	1.83
210008	Mercy	37646	14732	39.13	-1.61
210009	Johns Hopkins	89502	32898	36.76	0.49
210010	UM-Dorchester	14265	4245	29.76	2.09

EDDIE (Emergency Department Dramatic Improvement Effort)

- Monthly, public reporting of three measures:
  - ED1 Inpatient arrival to admission time
  - OP18 Outpatient ED arrival to discharge time
  - EMS turnaround time (data from MIEMSS)

- Hospital reporting:
  - Monthly reporting of ED1 and OP18 starting in July or August
  - Data will be used for public reporting at Commission meetings and other venues
  - HSCRC staff have been told this is feasible since most hospitals already monitor wait time data
  - Hospitals who do not report on monthly basis will be listed in public report
  - HSCRC will provide excel reporting template with high level specifications

Rationale:

Commission is prioritizing immediate reporting of ED wait time data for public reporting, while developing payment incentives for CY 2024.

Monthly, publicly reported of timely ED wait time should drive improvement.

HSCRC RY25 Policy Review-CRISP

June 2023

7160 Columbia Gateway Drive, Suite 100
Columbia, MD 21046
877.952.7477 | info@crisphealth.org
www.crisphealth.org

CRISP Reporting Services (CRS) Introduction

7160 Columbia Gateway Drive, Suite 100
Columbia, MD 21046
877.952.7477 | info@crisphealth.org
www.crisphealth.org

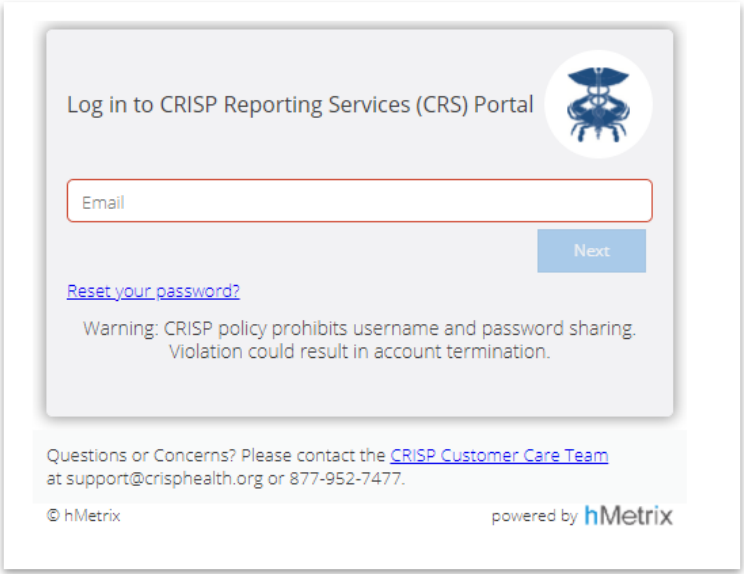
CRISP Reporting Services

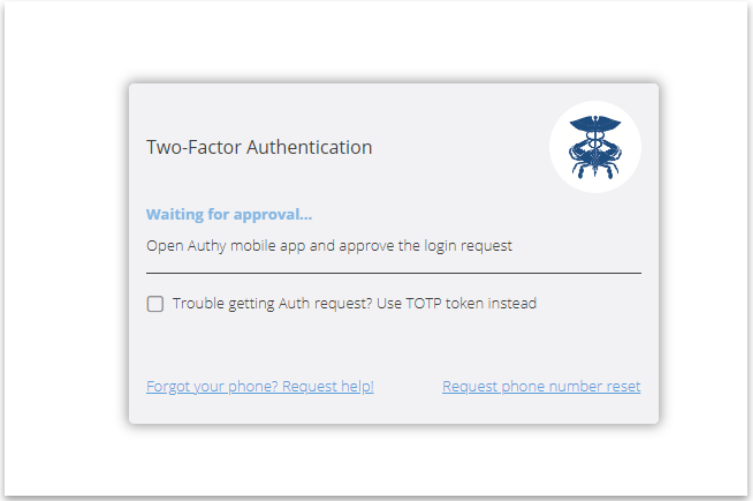
- CRS (reports.crisphealth.org) hosts reports for the HSCRC Quality Programs.
- HSCRC Regulatory reports and SIHIS Directional Indicators are refreshed once per month (beginning and middle of the month, respectively)

CRS Login Page – reports.crisphealth.org

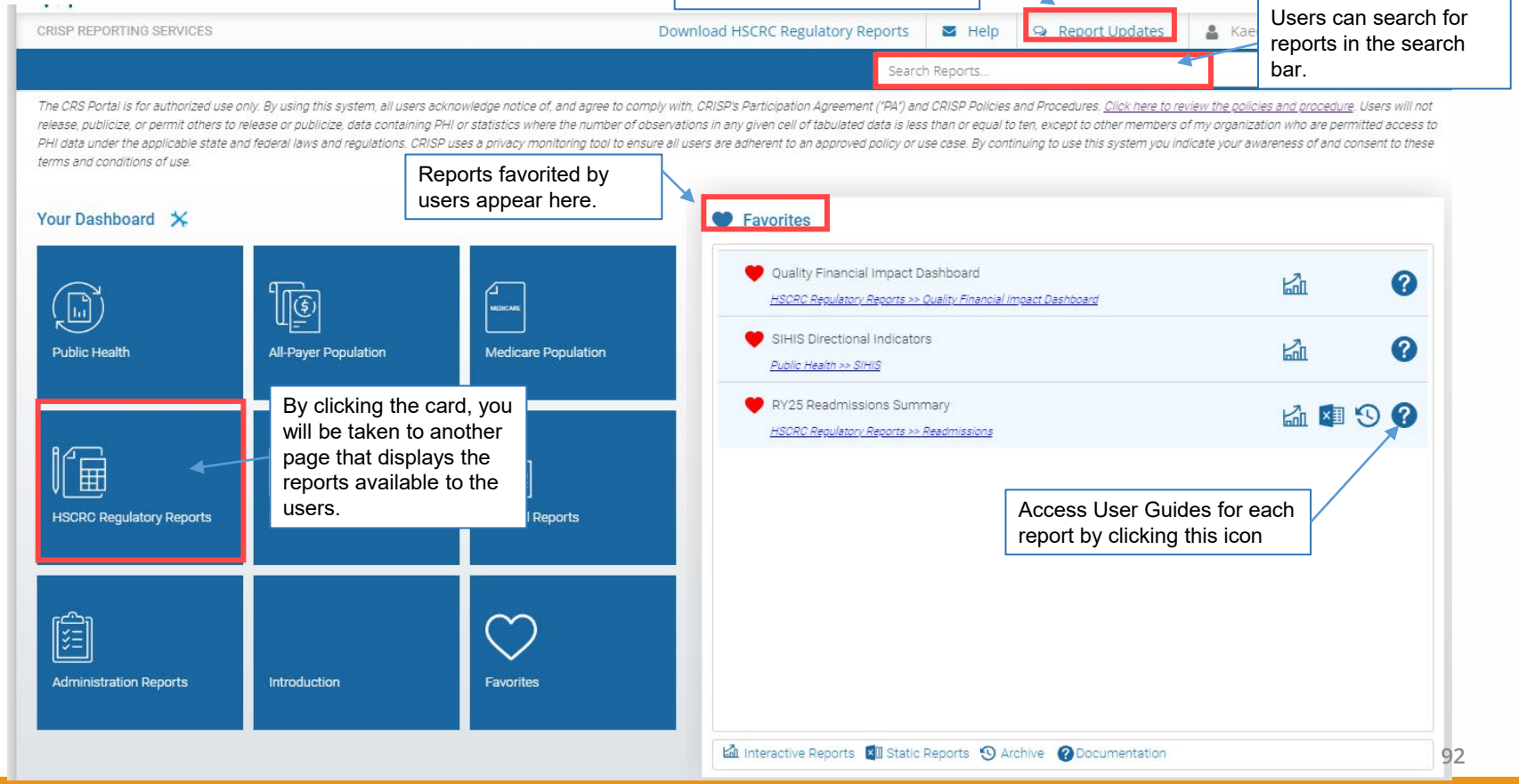
You can access CRS at reports.crisphealth.org with your User ID, password, and accepting the Authy two factor authentication notification.

If you do not have access to CRS, please reach out to support@crisphealth.org or the CRS Point of Contact for your organization

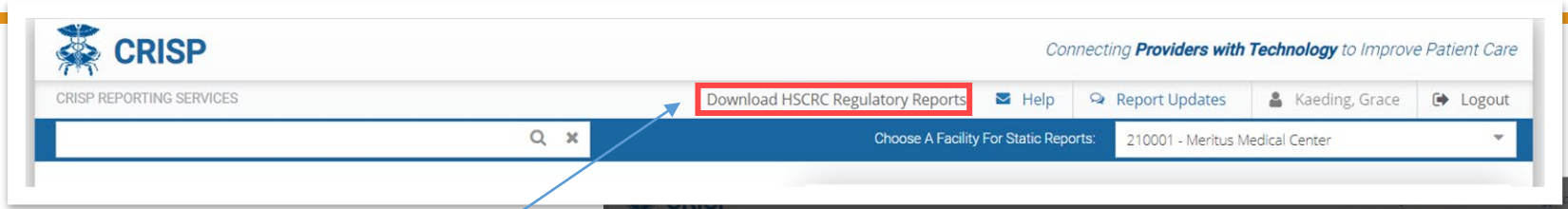




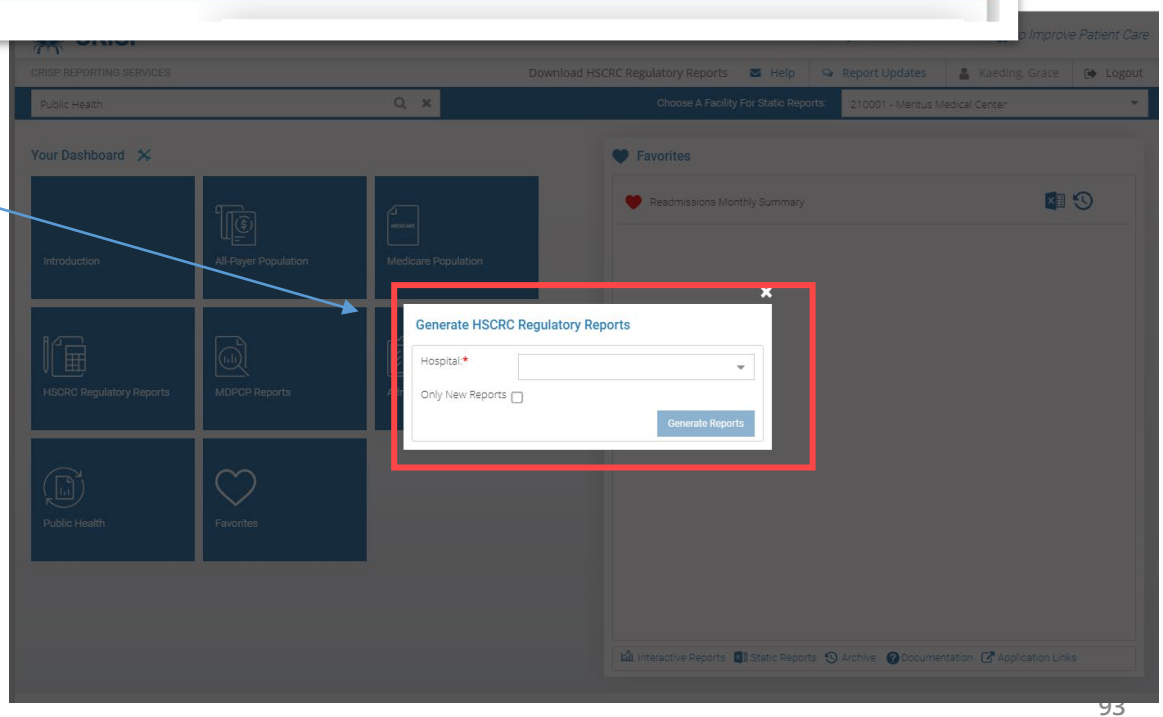
CRS Homepage



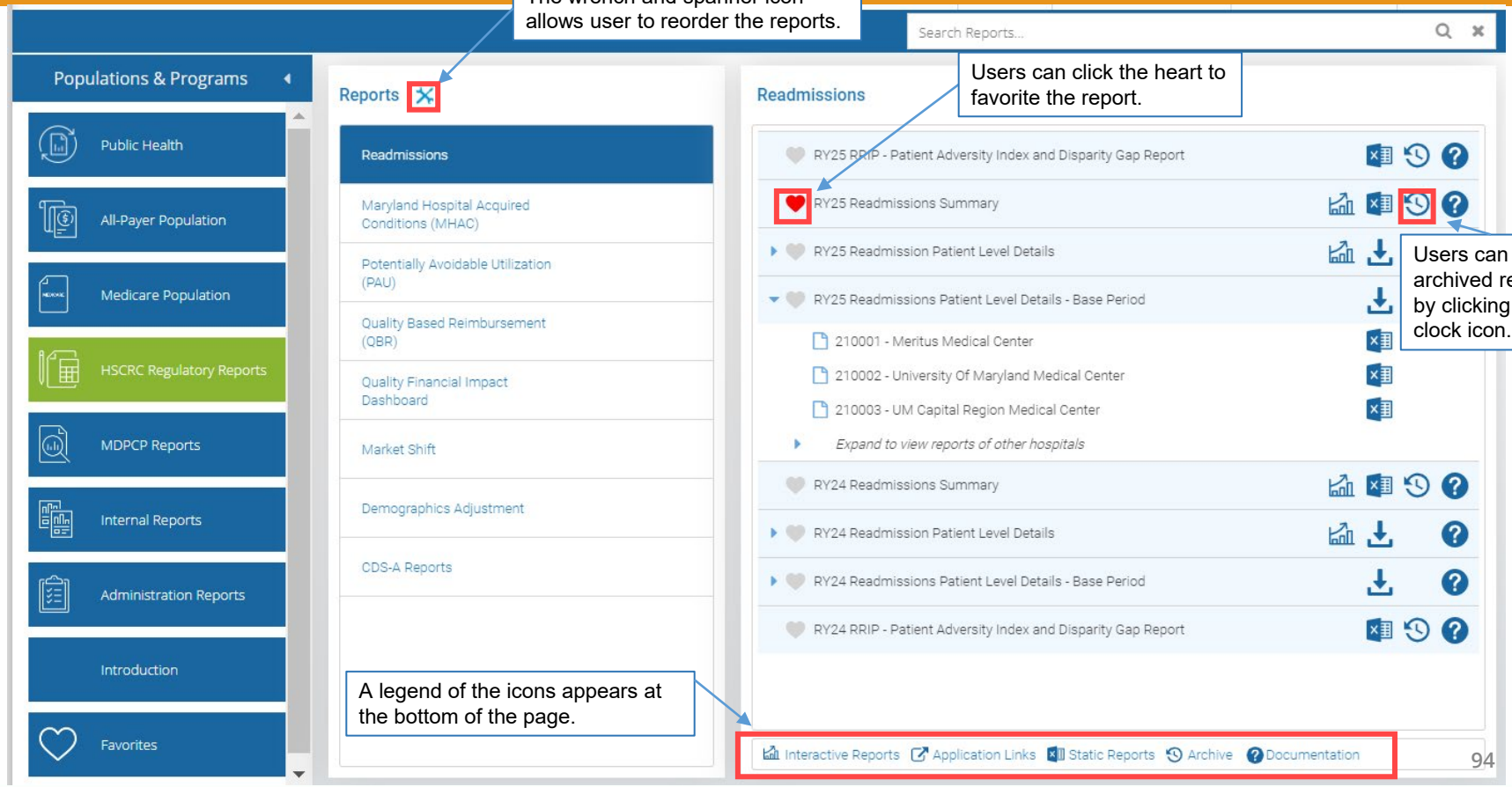
CRS Homepage



Users can download all the Static HSCRC Regulatory Reports at once. By clicking on the Download HSCRC Regulatory Reports button, the Generate HSCRC Regulatory Reports pop-out window will appear. Users can select multiple hospitals. To download the most recent reports, click the Only New Reports check box.



CRS HSCRC Regulatory Reports



Quality Financial Impact Dashboard (QFID)

7160 Columbia Gateway Drive, Suite 100
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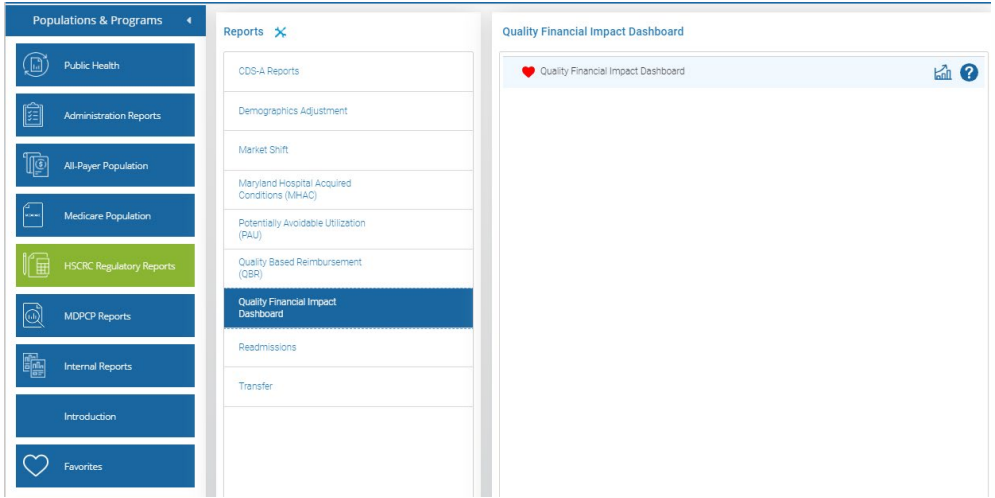
877.952.7477 | info@crisphealth.org
www.crisphealth.org

Background on Quality Financial Impact Dashboard

Purpose of the Dashboard:

- **To give executive leadership high-level insight on their year-to-date performance in the quality pay-for-performance programs as it relates to the overall budget in the Global Budget Revenue (GBR) model**



Report Features

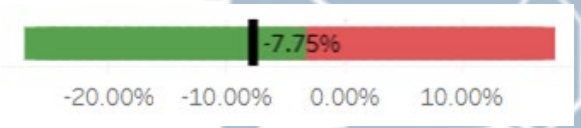
The hospital filter at the top of the screen allows users to select which hospital(s) they want to view in the dashboard. Please select “Apply” after selecting the hospitals.

The green to red bar shows users how close or far they are from the reward/penalty cutpoint.

Red indicates performance that would receive a penalty

Blue (if applicable) represents a revenue-neutral “hold harmless zone”

Green represents performance receiving a reward

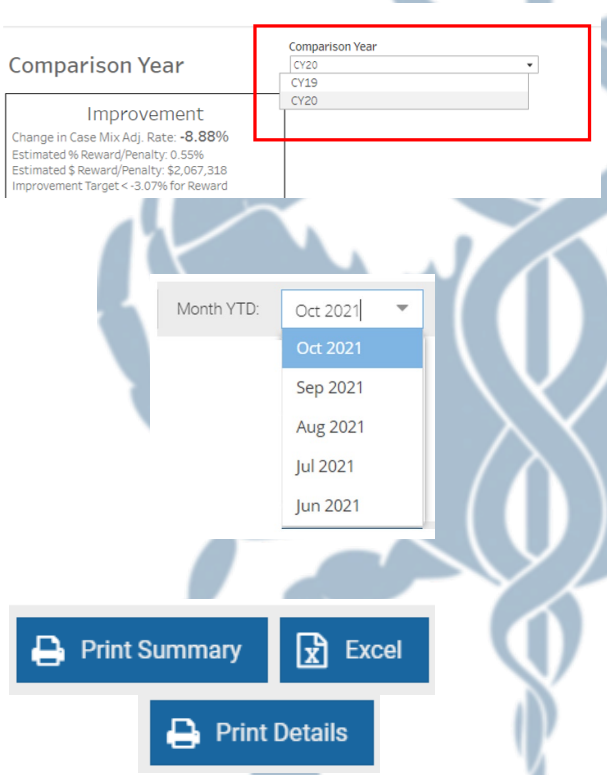


QFID Report Features

The comparison year on the left half of the screen allows users to change what year they are comparing against the current year. Please note that comparison years will use the current year's rate logic

The "Month YTD" filter allows users to change which data load they are using as the current performance period.

The Excel and Print features allows the users to export the report they are viewing.



QFID Caveats and Notes

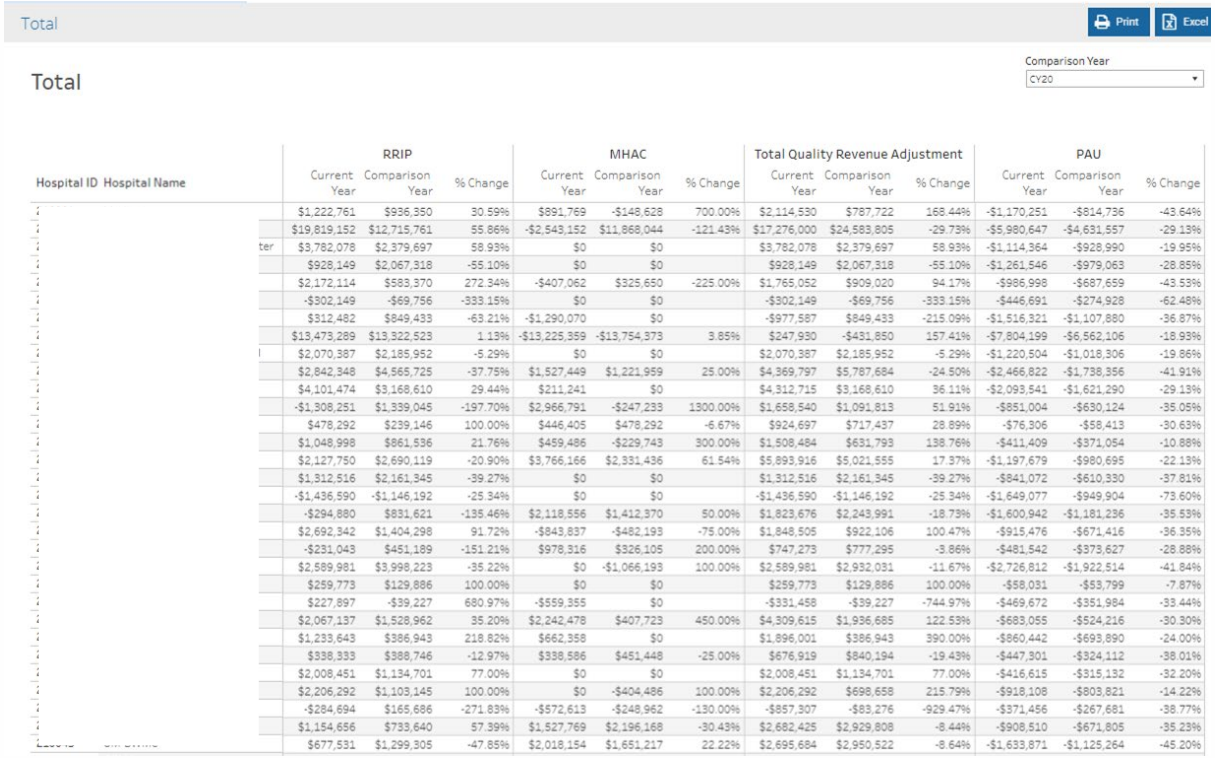
- The revenue adjustments in this dashboard are estimates, based on a hospital's last approved global budget
  - These revenue adjustment estimates will be updated to exact totals for the current rate-year through the update factor process at the end of the fiscal year
  - The revenue percentages are also provided, and hospitals are welcome to apply these percentages against their current global budget projections
- Hospital rankings are calculated by sorting on "% Reward/Penalty" from highest percent reward
- Current performance and financial impact are calculated to reflect the performance to-date and resultant financial impact, and will be updated throughout the year as new data become available
- RY25 methodology will be updated in the report on July 14th, 2023

QFID Tabs

QFID has five tabs: one for the total financial impact and one for each of the four quality programs with each program's current performance year financial impact and salient performance metrics. To view a page, the user must click on the box for the tab they want to view

Summary View Total Tab

The Total page allows users to view the current and comparison years along with the % change for each of the quality programs and the total quality revenue adjustment.



Total

Print Excel

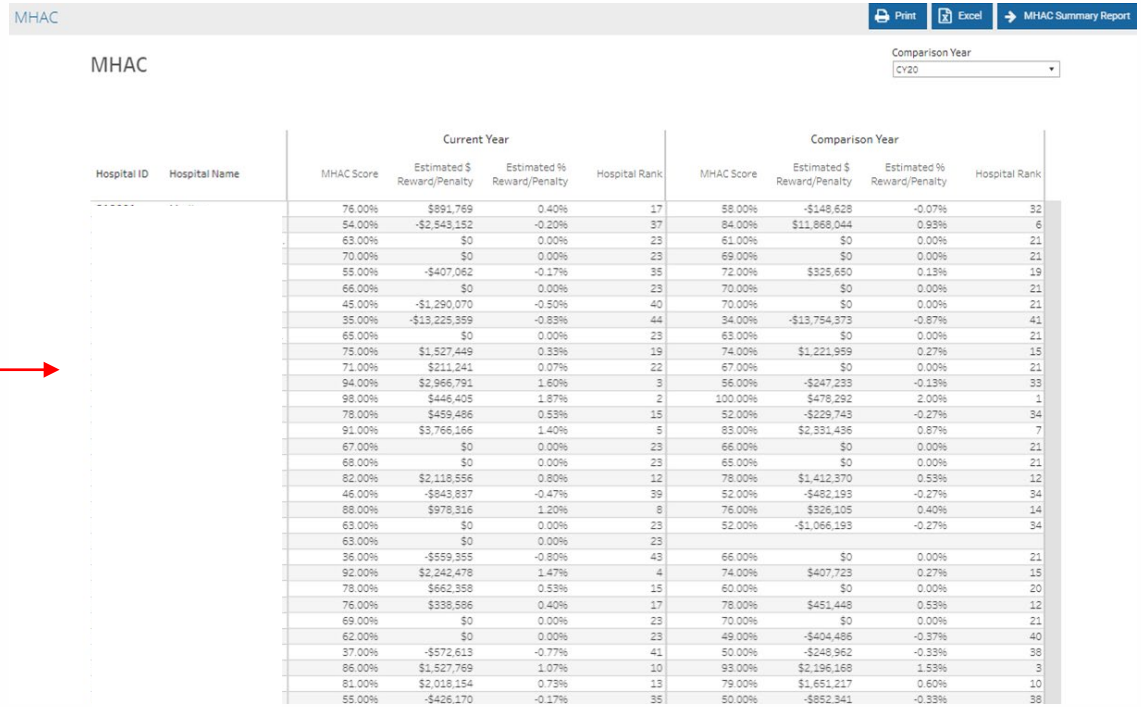
Total

Comparison Year: CY20

Hospital ID	Hospital Name	RRIP Current Year	RRIP Comparison Year	RRIP % Change	MHAC Current Year	MHAC Comparison Year	MHAC % Change	Total Quality Revenue Adjustment Current Year	Total Quality Revenue Adjustment Comparison Year	Total Quality Revenue Adjustment % Change	PAU Current Year	PAU Comparison Year	PAU % Change
		$1,222,761	$936,350	30.59%	$891,769	-$148,628	700.00%	$2,114,530	$787,722	168.44%	-$1,170,251	-$814,736	-43.64%
		$19,819,152	$12,715,761	55.86%	-$2,543,152	$11,868,044	-121.43%	$17,276,000	$24,583,805	-29.73%	-$5,980,647	-$4,631,557	-29.13%
	ter	$3,782,078	$2,379,697	58.93%	$0	$0		$3,782,078	$2,379,697	58.93%	-$1,114,364	-$928,990	-19.95%
		$928,149	$2,067,318	-55.10%	$0	$0		$928,149	$2,067,318	-55.10%	-$1,261,546	-$979,063	-28.85%
		$2,172,114	$583,370	272.34%	-$407,062	$325,650	-225.00%	$1,765,052	$909,020	94.17%	-$986,998	-$687,659	-43.53%
		-$302,149	-$69,756	-333.15%	$0	$0		-$302,149	-$69,756	-333.15%	-$446,691	-$274,928	-62.48%
		$312,482	$849,433	-63.21%	-$1,290,070	$0		-$977,587	$849,433	-215.09%	-$1,516,321	-$1,107,880	-36.87%
		$13,473,289	$13,322,523	1.13%	-$13,225,359	-$13,754,373	3.85%	$247,930	-$431,850	157.41%	-$7,804,199	-$6,562,106	-18.93%
		$2,070,387	$2,185,952	-5.29%	$0	$0		$2,070,387	$2,185,952	-5.29%	-$1,220,504	-$1,018,306	-19.86%
		$2,842,348	$4,565,725	-37.75%	$1,527,449	$1,221,959	25.00%	$4,369,797	$5,787,684	-24.50%	-$2,466,822	-$1,738,356	-41.91%
		$4,101,474	$3,168,610	29.44%	$211,241	$0		$4,312,715	$3,168,610	36.11%	-$2,093,541	-$1,621,290	-29.13%
		-$1,308,251	$1,339,045	-197.70%	$2,966,791	-$247,233	1300.00%	$1,658,540	$1,091,813	51.91%	-$851,004	-$630,124	-35.05%
		$478,292	$239,146	100.00%	$446,405	$478,292	-6.67%	$924,697	$717,437	28.89%	-$76,306	-$58,413	-30.63%
		$1,048,998	$861,536	21.76%	$459,486	-$229,743	300.00%	$1,508,484	$631,793	138.76%	-$411,409	-$371,054	-10.88%
		$2,127,750	$2,690,119	-20.90%	$3,766,166	$2,331,436	61.54%	$5,893,916	$5,021,555	17.37%	-$1,197,679	-$980,695	-22.13%
		$1,312,516	$2,161,345	-39.27%	$0	$0		$1,312,516	$2,161,345	-39.27%	-$841,072	-$610,330	-37.81%
		-$1,436,590	-$1,146,192	-25.34%	$0	$0		-$1,436,590	-$1,146,192	-25.34%	-$1,649,077	-$949,904	-73.60%
		-$294,880	$831,621	-135.46%	$2,118,556	$1,412,370	50.00%	$1,823,676	$2,243,991	-18.73%	-$1,600,942	-$1,181,236	-35.53%
		$2,692,342	$1,404,298	91.72%	-$843,837	-$482,193	-75.00%	$1,848,505	$922,106	100.47%	-$915,476	-$671,416	-36.35%
		-$231,043	$451,189	-151.21%	$978,316	$326,105	200.00%	$747,273	$777,295	-3.86%	-$481,542	-$373,627	-28.88%
		$2,589,981	$3,998,223	-35.22%	$0	-$1,066,193	100.00%	$2,589,981	$2,932,031	-11.67%	-$2,726,812	-$1,922,514	-41.84%
		$259,773	$129,886	100.00%	$0	$0		$259,773	$129,886	100.00%	-$58,031	-$53,799	-7.87%
		$227,897	-$39,227	680.97%	-$559,355	$0		-$331,458	-$39,227	-744.97%	-$469,672	-$351,984	-33.44%
		$2,067,137	$1,528,962	35.20%	$2,242,478	$407,723	450.00%	$4,309,615	$1,936,685	122.53%	-$683,055	-$524,216	-30.30%
		$1,233,643	$386,943	218.82%	$662,358	$0		$1,896,001	$386,943	390.00%	-$860,442	-$693,890	-24.00%
		$338,333	$388,746	-12.97%	$338,586	$451,448	-25.00%	$676,919	$840,194	-19.43%	-$447,301	-$324,112	-38.01%
		$2,008,451	$1,134,701	77.00%	$0	$0		$2,008,451	$1,134,701	77.00%	-$416,615	-$315,132	-32.20%
		$2,206,292	$1,103,145	100.00%	$0	-$404,486	100.00%	$2,206,292	$698,658	215.79%	-$918,108	-$803,821	-14.22%
		-$284,694	$165,686	-271.83%	-$572,613	-$248,962	-130.00%	-$857,307	-$83,276	-929.47%	-$371,456	-$267,681	-38.77%
		$1,154,656	$733,640	57.39%	$1,527,769	$2,196,168	-30.43%	$2,682,425	$2,929,808	-8.44%	-$908,510	-$671,805	-35.23%
		$677,531	$1,299,305	-47.85%	$2,018,154	$1,651,217	22.22%	$2,695,684	$2,950,522	-8.64%	-$1,633,871	-$1,125,264	-45.20%

Summary View MHAC (Maryland Hospital Acquired Conditions) Tab

The multi hospital view shows the MHAC score, estimated reward/penalty in percent and dollars as well as the hospital rank for the selected hospital(s). The same measures are available for the comparison year.



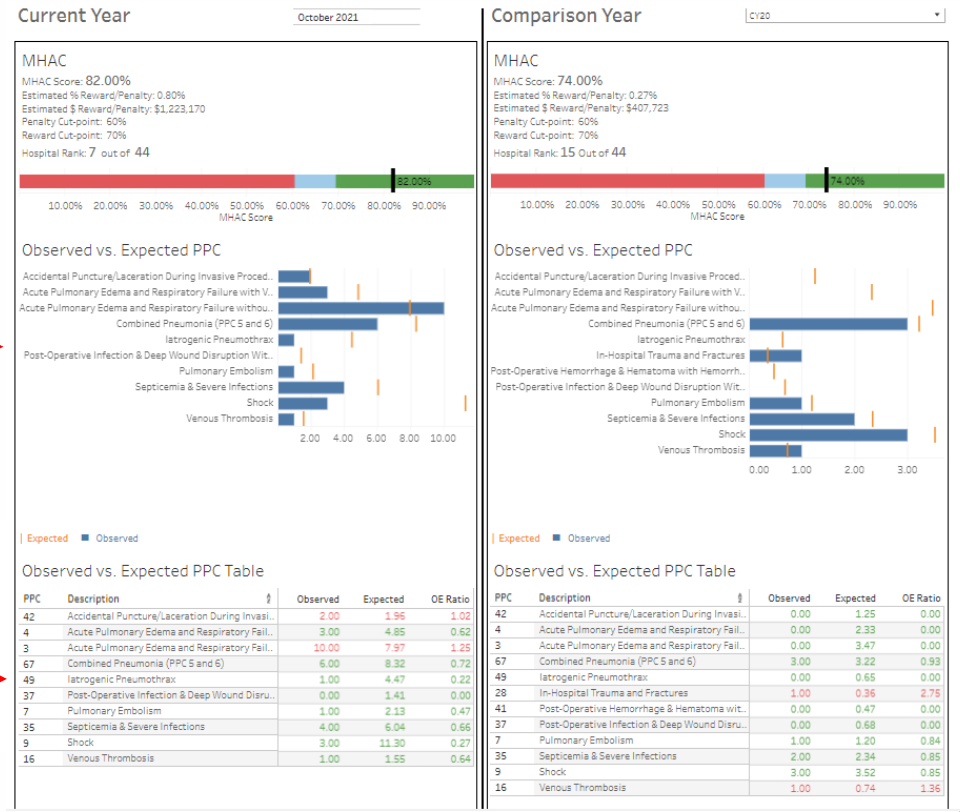
Hospital ID	Hospital Name	Current Year				Comparison Year			
		MHAC Score	Estimated $ Reward/Penalty	Estimated % Reward/Penalty	Hospital Rank	MHAC Score	Estimated $ Reward/Penalty	Estimated % Reward/Penalty	Hospital Rank
		76.00%	$891,769	0.40%	17	58.00%	-$148,628	-0.07%	32
		54.00%	-$2,543,152	-0.20%	37	84.00%	$11,868,044	0.93%	6
		63.00%	$0	0.00%	23	61.00%	$0	0.00%	21
		70.00%	$0	0.00%	23	69.00%	$0	0.00%	21
		55.00%	-$407,062	-0.17%	35	72.00%	$325,650	0.13%	19
		66.00%	$0	0.00%	23	70.00%	$0	0.00%	21
		45.00%	-$1,290,070	-0.50%	40	70.00%	$0	0.00%	21
		35.00%	-$13,225,359	-0.83%	44	34.00%	-$13,754,373	-0.87%	41
		65.00%	$0	0.00%	23	63.00%	$0	0.00%	21
		75.00%	$1,527,449	0.33%	19	74.00%	$1,221,959	0.27%	15
		71.00%	$211,241	0.07%	22	67.00%	$0	0.00%	21
		94.00%	$2,966,791	1.60%	3	56.00%	-$247,233	-0.13%	33
		98.00%	$446,405	1.87%	2	100.00%	$478,292	2.00%	1
		78.00%	$459,486	0.53%	15	52.00%	-$229,743	-0.27%	34
		91.00%	$3,766,166	1.40%	5	83.00%	$2,331,436	0.87%	7
		67.00%	$0	0.00%	23	66.00%	$0	0.00%	21
		68.00%	$0	0.00%	23	65.00%	$0	0.00%	21
		82.00%	$2,118,556	0.80%	12	78.00%	$1,412,370	0.53%	12
		46.00%	-$843,837	-0.47%	39	52.00%	-$482,193	-0.27%	34
		88.00%	$978,316	1.20%	8	76.00%	$326,105	0.40%	14
		63.00%	$0	0.00%	23	52.00%	-$1,066,193	-0.27%	34
		63.00%	$0	0.00%	23				
		36.00%	-$559,355	-0.80%	43	66.00%	$0	0.00%	21
		92.00%	$2,242,478	1.47%	4	74.00%	$407,723	0.27%	15
		78.00%	$662,358	0.53%	15	60.00%	$0	0.00%	20
		76.00%	$338,586	0.40%	17	78.00%	$451,448	0.53%	12
		69.00%	$0	0.00%	23	70.00%	$0	0.00%	21
		62.00%	$0	0.00%	23	49.00%	-$404,486	-0.37%	40
		37.00%	-$572,613	-0.77%	41	50.00%	-$248,962	-0.33%	38
		86.00%	$1,527,769	1.07%	10	93.00%	$2,196,168	1.53%	3
		81.00%	$2,018,154	0.73%	13	79.00%	$1,651,217	0.60%	10
		55.00%	-$426,170	-0.17%	35	50.00%	-$852,341	-0.33%	38

Detail View MHAC Tab

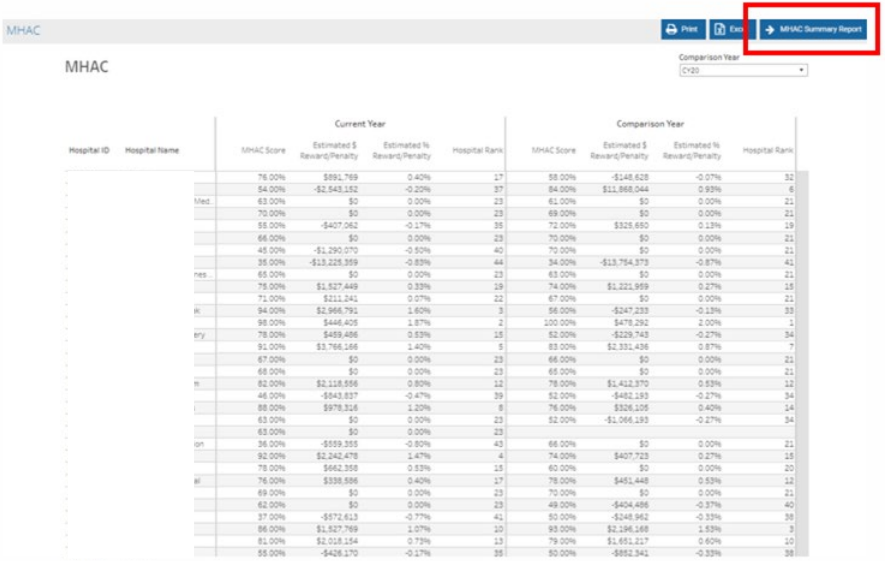
MHAC tab includes: MHAC score, estimated percent reward/penalty, estimated financial reward/penalty, hospital rank for MHAC, and tables for the observed versus expected PPC

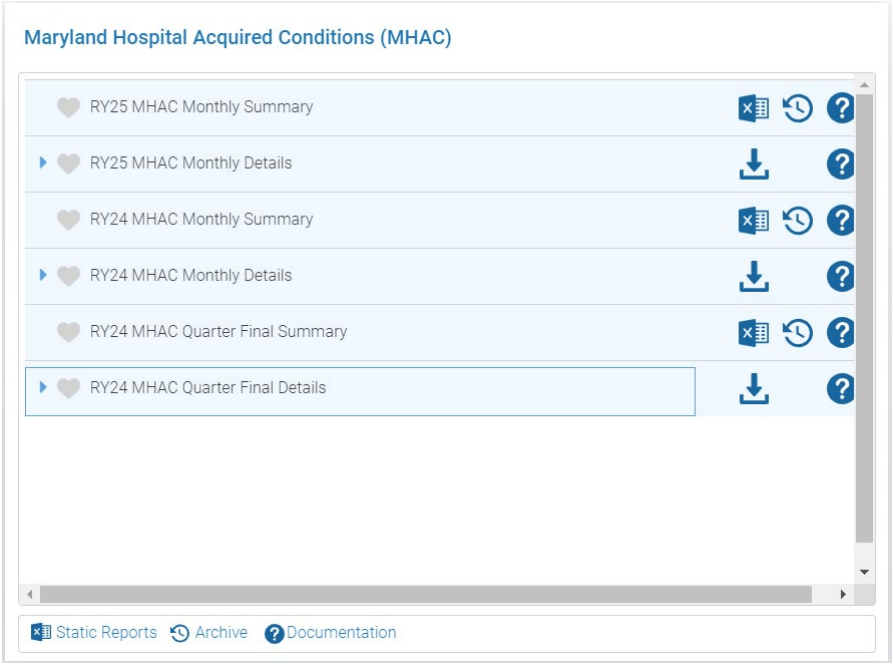
First table shows the PPCs the hospital is being held accountable. The blue bar is the observed PPC occurrence; the orange line is the expected

The second PPC tables the actual values for each PPC and the OE ratio. Red means the observed is higher than expected and green means the observed is lower than expected



MHAC Additional Reports





Clicking the “MHAC Summary Report” button at the top right on either the summary or details page will launch the full selection of reports supporting the MHAC Program.

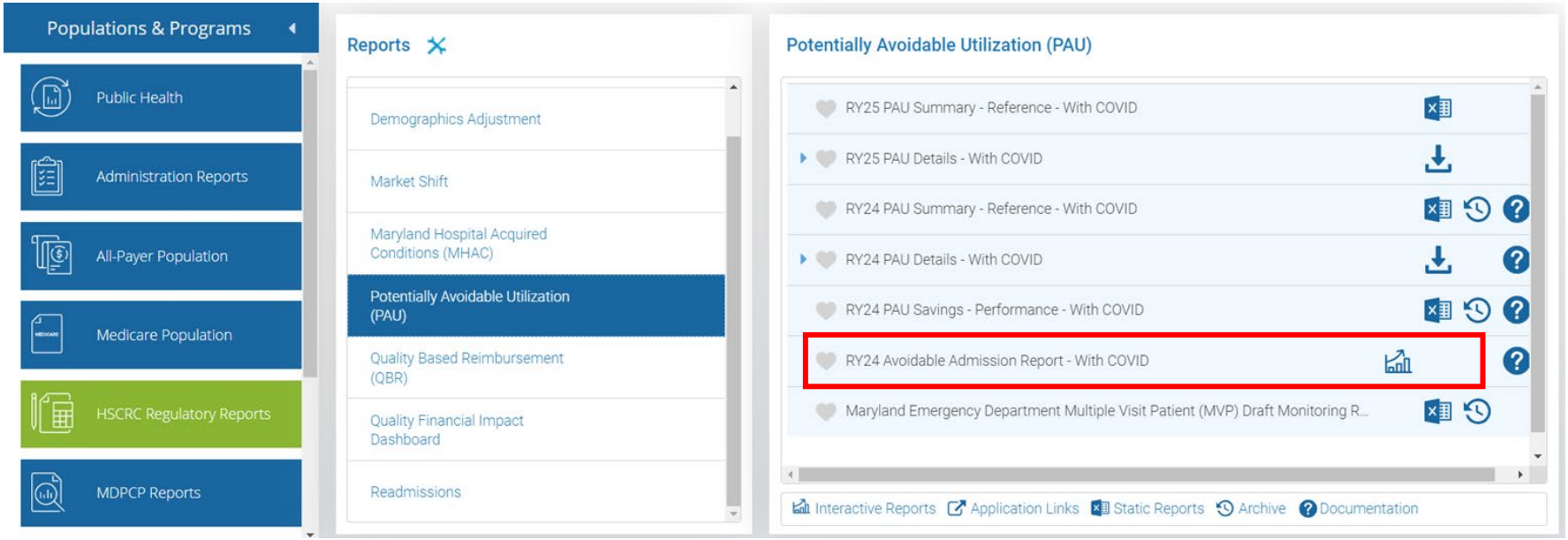
Avoidable Admissions Report

7160 Columbia Gateway Drive, Suite 100
Columbia, MD 21046
877.952.7477 | info@crisphealth.org
www.crisphealth.org

Avoidable Admissions Report

- The Avoidable Admissions Report allows users to see per capita Prevention Quality Indicators (PQI) and Pediatric Quality Indicators (PDI) values.
- The report displays PQIs and PDIs that are assigned to hospitals based on geographic attribution.
- The following tabs are available:
  - Savings Performance
  - Summary by PQI
  - Summary by PDI
  - PQIs by Zip

Avoidable Admissions Report



Filters

Filter	Description
Year	Year in which the PQI occurred.
Hospital Name	Hospital to which the PQIs are attributed. This is not necessarily the hospital where the visit occurred.
Payer	Primary expected payer as listed in case mix data
Gender	Patient Gender
Age Group	Patient Age, distributed into available ACS census age groups.

Avoidable Admissions Report

Avoidable Admissions Report

Adults Summary by PQI

	Population Adult	Overall Composite	Overall Composite per 1000	Diabetes Composite	Diabetes Composite per 1000	Acute Composite	Acute Composite per 1000	COPD/ Asthma	COPD/Asthm per 1000	Hyperten..	Hypertensio per 1000	Congestive Heart Failure	Congestive Heart Failure per 1000
Statewide	4,730,712	49,447	10.45	10,869	2.30	9,821	2.08	8,942	1.89	3,364	0.71	16,457	3.48
Selected Hospitals Subtotal	4,615,659	48,600	10.53	10,689	2.32	9,622	2.08	8,780	1.90	3,318	0.72	16,197	3.51
	119,281	1,974	16.55	415	3.48	462	3.87	538	4.51	95	0.80	464	3.89
	43,952	882	20.06	221	5.04	108	2.45	172	3.91	93	2.11	288	6.54
	91,364	1,103	12.07	267	2.93	158	1.73	182	1.99	84	0.92	412	4.51
	223,332	1,404	6.29	332	1.49	322	1.44	165	0.74	106	0.48	479	2.14
	203,384	1,628	8.00	331	1.63	408	2.01	332	1.63	93	0.46	465	2.29
	36,640	530	14.48	101	2.77	111	3.04	119	3.26	31	0.86	168	4.57
	75,248	1,447	19.23	356	4.74	188	2.50	299	3.98	142	1.89	461	6.13
	50,393	1,061	21.06	259	5.14	132	2.62	246	4.88	99	1.96	326	6.46
	120,813	1,509	12.49	369	3.06	269	2.23	249	2.06	132	1.09	490	4.05
	147,537	2,343	15.88	518	3.51	421	2.86	382	2.59	174	1.18	848	5.75
	109,546	2,016	18.41	380	3.47	355	3.24	476	4.34	122	1.11	684	6.24
	220,011	1,475	6.70	368	1.67	273	1.24	200	0.91	115	0.52	519	2.36
	18,733	185	9.88	41	2.19	46	2.46	46	2.46	7	0.37	45	2.40
	89,911	609	6.78	120	1.34	161	1.79	81	0.90	39	0.43	209	2.32
	127,250	1,134	8.91	294	2.31	210	1.65	183	1.44	113	0.89	335	2.63
	208,824	977	4.68	175	0.84	272	1.30	105	0.50	53	0.25	371	1.78
	236,904	2,287	9.65	422	1.78	594	2.51	378	1.60	62	0.26	831	3.51
	81,170	1,462	18.01	339	4.17	203	2.50	287	3.54	154	1.90	479	5.90
	65,227	969	14.86	163	2.50	209	3.20	211	3.23	64	0.98	322	4.94
	91,028	1,085	11.92	197	2.16	223	2.45	221	2.43	74	0.81	370	4.06
	63,529	1,211	19.07	275	4.33	164	2.58	278	4.37	91	1.44	404	6.36
	72,945	1,013	13.88	211	2.89	256	3.51	268	3.68	46	0.63	232	3.18
	138,634	1,583	11.42	268	1.93	496	3.58	298	2.15	62	0.45	459	3.31
	32,738	580	17.71	151	4.61	88	2.68	162	4.96	40	1.23	138	4.23
	119,065	866	7.27	231	1.94	153	1.29	146	1.23	43	0.36	293	2.46
	27,014	583	21.58	139	5.15	74	2.74	103	3.81	68	2.53	199	7.36
	73,939	611	8.26	163	2.20	98	1.33	97	1.31	13	0.18	240	3.25

Year Selection
2022

Hospital Name
(Multiple values)

Attribution Category
(All)

Gender
(All)

Age Group
(All)

Race
(All)

Payer
(affects numerator only)
(All)

Casemix Data Available Through:
4/30/2023

PQI rates do not include risk adjustment methodology.
AHRQ PQI version 2021.
Data is annualized so that calendar year to date data is presented as if that rate continued for the rest of the year. Data is refreshed monthly.
Census-based population data is refreshed as it becomes publicly available.
MPA Y5 (RY2024) attribution is used for the MPA portion of the algorithm. See User Guide for further explanation.

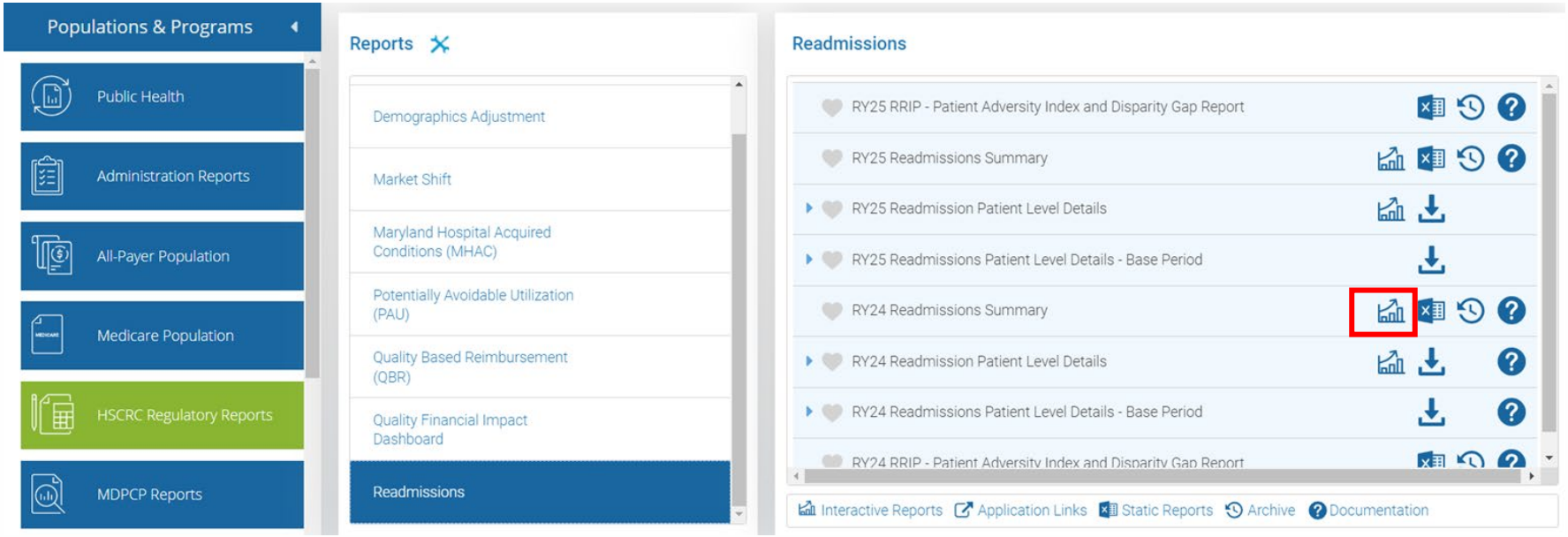
Readmissions Summary

7160 Columbia Gateway Drive, Suite 100
Columbia, MD 21046
877.952.7477 | info@crisphealth.org
www.crisphealth.org

Readmissions Summary Overview

- The report allows users to filter and drilldown their hospital's readmission data.
- The following tabs are available
  - Landing Page
  - Improvement
  - Attainment
  - Trends & Locations
  - Unadjusted Hospital Readmission Trends
  - Case-mix Adjusted Readmission Trends
  - Service Line Readmission Analysis
  - Length of Discharge to Readmission (Requires PHI access)
  - Forecasting
  - Patient Level Details (Requires PHI access)
  - Documentation
  - Summary by Month

Readmissions Summary

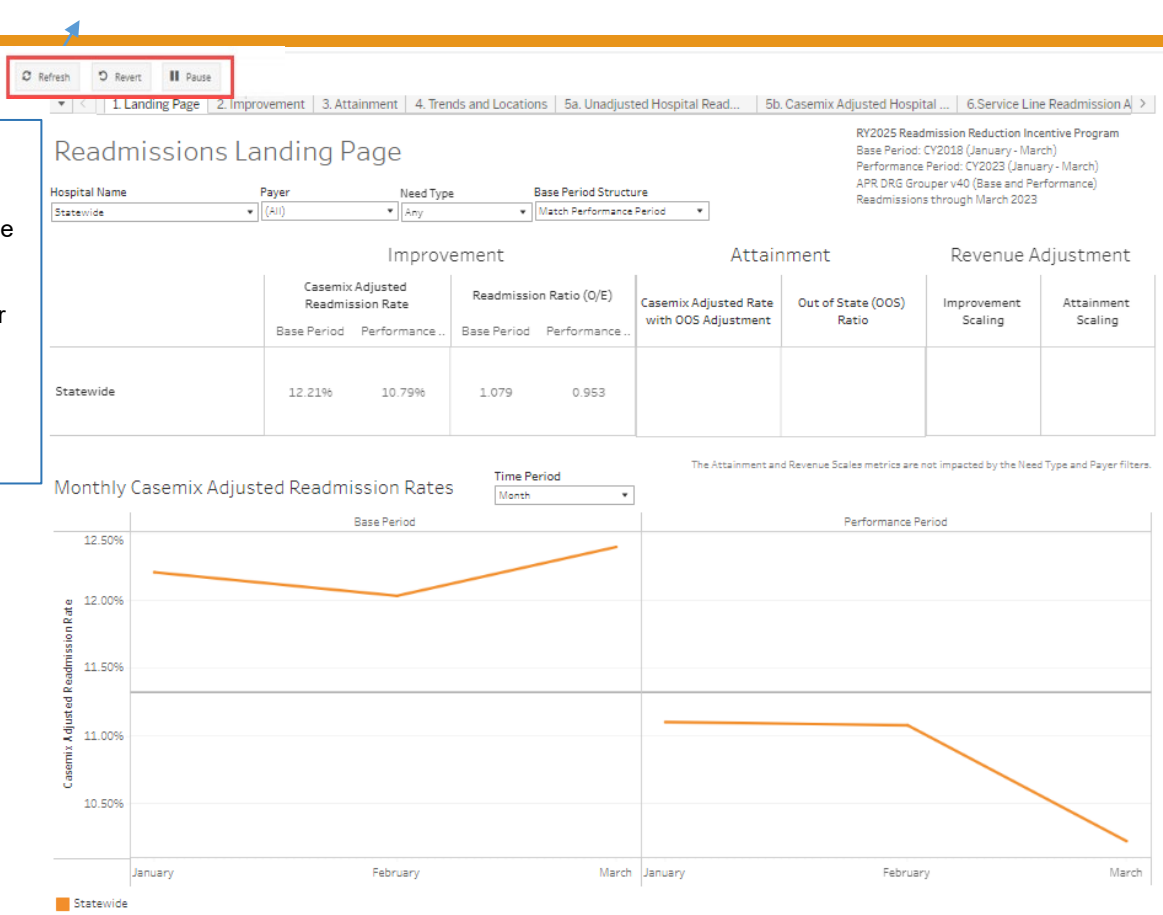


Filters

Filter	Description
Basic Period Structure	View either the complete base period (Based on CY2018 data) and/or matched YTD performance period.
Discharge Date	Select the year(s) of discharge.
Hospital Name	Filter on one or more hospitals
Index APR Service Line	Filter groups services into higher level categories, which is based on the index hospital.
Index APR Value	APR value from the index hospital.
Need Type	High Utilizer: 3+ bedded care visits (inpatient and observation stays over 24 hours) in the 12 months prior to their index visit Rising Needs: 2+ visits bedded care or ED in the 12 months before their index visit
Payer	Filter based on the type of payer (commercial, Medicare, Medicaid, and charity/self-pay)
Primary Diagnosis	Diagnosis at index visit
Race	Race reported by hospital at visit

Readmissions Summary

- Refresh – Used to refresh data for complex queries
- Revert – restores page to default view
- Pause – prevents the report from loading for each filter sections. Extremely useful if making multiple sections during a session.



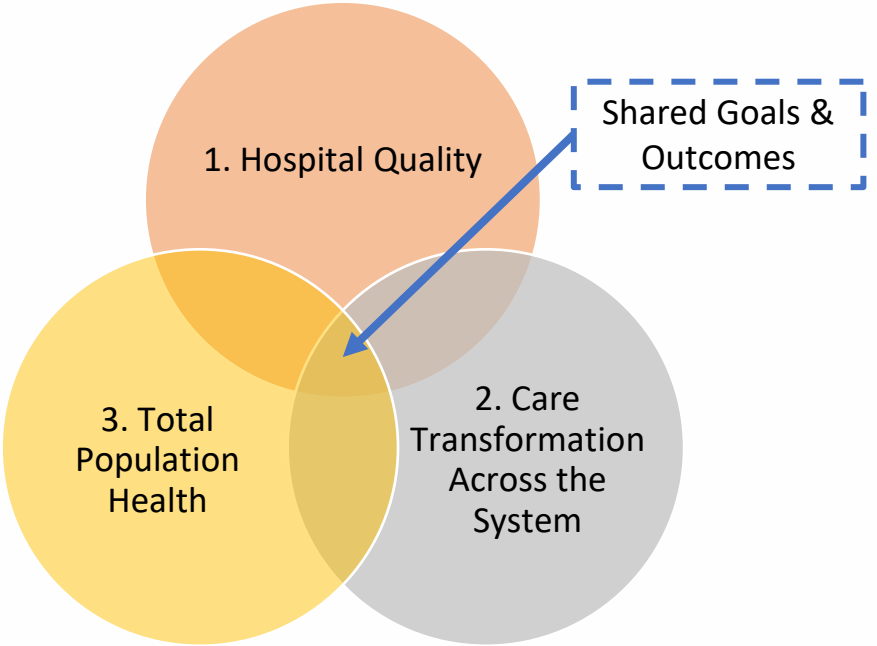
- Print – export view into a PDF

Statewide Integrated Health Improvement Strategy (SIHIS) Overview

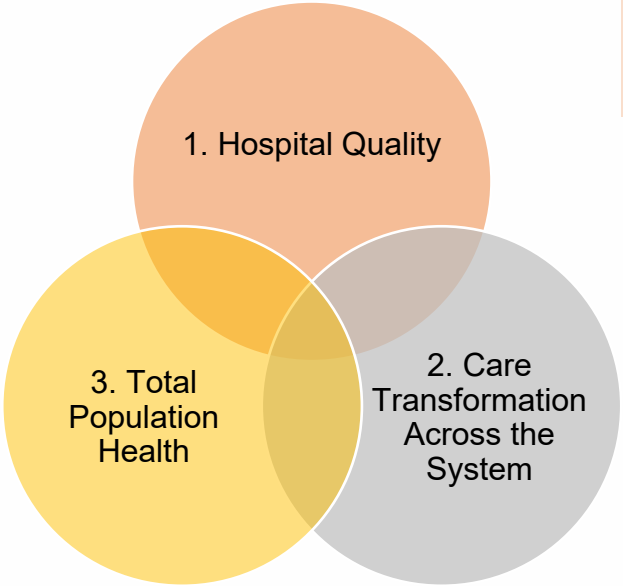
7160 Columbia Gateway Drive, Suite 100
Columbia, MD 21046
877.952.7477 | info@crisphealth.org
www.crisphealth.org

Statewide Integrated Health Improvement Strategy (SIHIS)

- SIHIS is designed to engage State agencies and private-sector partners to collaborate and invest in improving health, addressing disparities, and reducing costs for Marylanders.
- CMMI approved the SIHIS goals in March 2021.
- More information on SIHIS can be found on the HSCRC website. https://hscrc.maryland.gov/Pages/Statewide-Integrated-Health-Improvement-Strategy-.aspx



Statewide Goals Across Three Domains



Hospital Quality

- Reduce avoidable admissions
- Improve Readmission Rates by Reducing Within-Hospital Disparities

Care Transformation Goals

- Increase the amount of Medicare TCOC or number of Medicare beneficiaries under value-based care models*
- Improve care coordination for patients with chronic conditions

Total Population Health Goals

- Priority Area 1 (Diabetes): Reduce the mean BMI for adult Maryland residents
- Priority Area 2 (Opioids): Improve overdose mortality
- Priority Area 3 (Maternal and Child Health):
  - Reduce severe maternal morbidity rate
  - Decrease asthma-related emergency department visit rates for ages 2-17

SIHIS Directional Indicators Dashboard Overview

- Many of the data sources used for official SIHIS monitoring are calculated annually on delayed data sources.
- CRISP partnered with HSCRC and MDH to identify proxy measures that would enable reporting in a timely fashion. The reporting suite is referred to as “directional indicators”
- The reports include either proxy or actual measures for all the SIHIS goals
- The reporting suite has separate modules for each of the domains: Hospital Quality; Care Transformation across the System; and Population Health
- The SIHIS Directional Indicators Dashboard is updated in the middle of the month

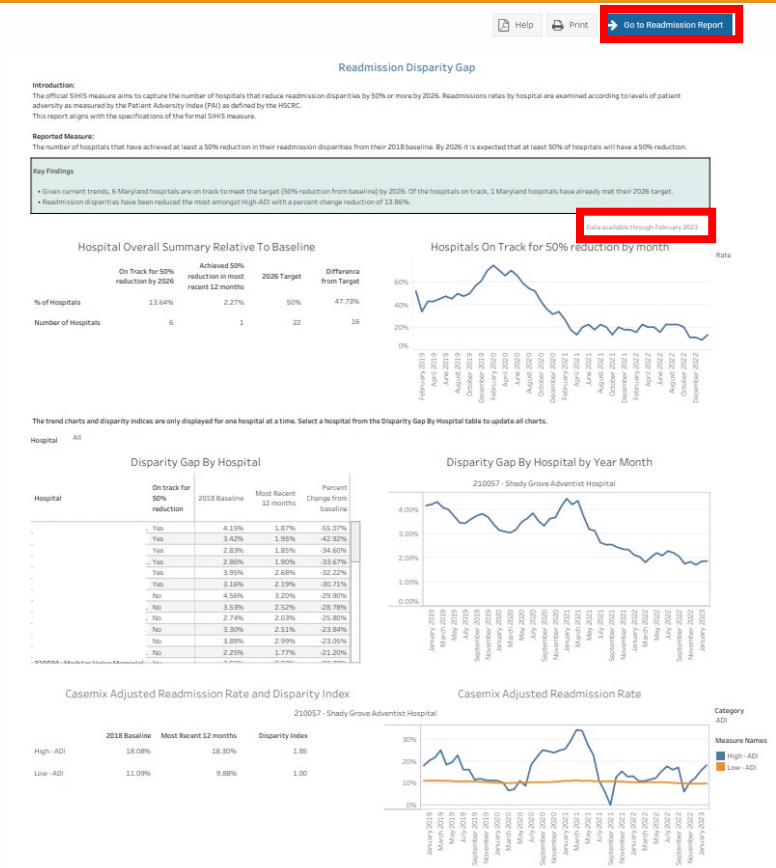
Readmissions Disparity Gap Directional Indicator Report

Introduction
- Measure aims to capture the number of hospitals that reduce readmission disparities by 50% or more by 2026.
- Readmission rates by hospital are examined according to levels of patient adversity as measured by the Patient Adversity Index (PAI).

Reported Measure
- Reported in Casemix data
- Success in the measure is defined as at least 50% of hospitals having achieved at least a 50%

Key Findings
- Presents the big picture findings
  - 6 Maryland hospitals are on track to meet the target by 2026
- There is a lag in the data presented
  - Data available through date in top right corner of chart

Readmissions Disparity Gap Comparison Charts
- Able to view and filter by hospital to see which hospitals are on track and how each hospitals trends by the categories of PAI.



Support and Training

- To request access or support with credentialing, contact support@crisphealth.org
- For questions about the reports within CRS or suggestions for report enhancements contact report-support@crisphealth.org
- Detailed User Guides are available for all reports on the CRS website
- Webinars on select reports are on the CRISP Learning System website (crisphealth.org/learning-system/crs)

Accessing Reports

- Email your Organization's CRS Point of Contact (POC) to request access to portal:
  - Request should specify hospital and level of access (summary vs. case-level)
  - Access will be granted to all hospital reports (i.e., not program specific)
- CRS Point of Contact (CFO or designee) confirm and approve access requests for each organization
- Questions regarding **content** of static reports or report **policy** should be directed to the HSCRC quality email (hscrc.quality@maryland.gov)
- Questions regarding **access** issues or **tableau** reports should be directed to CRISP Support email (support@crisphealth.org)

Non-HSCRC Quality Resources

- Why Not the Best?
- CMS Care Compare
- MHCC Health Care Quality Reports
- QualityNet
- LeapFrog Hospital Safety Grades
- US News & World Report - Hospital Rankings
- Commonwealth Fund Report

Acknowledgments

Thanks to the Performance Measurement Work Group members, MHA, CRISP, the hospital industry, consumers, and other stakeholders for their work on developing and vetting Maryland's performance-based payment methodologies.

Q & A

- Please type your Question into the Questions Bar
- Additional or unanswered questions can be emailed to the HSCRC Quality mailbox: hscrc.quality@maryland.gov
- Thank you again for your participation!